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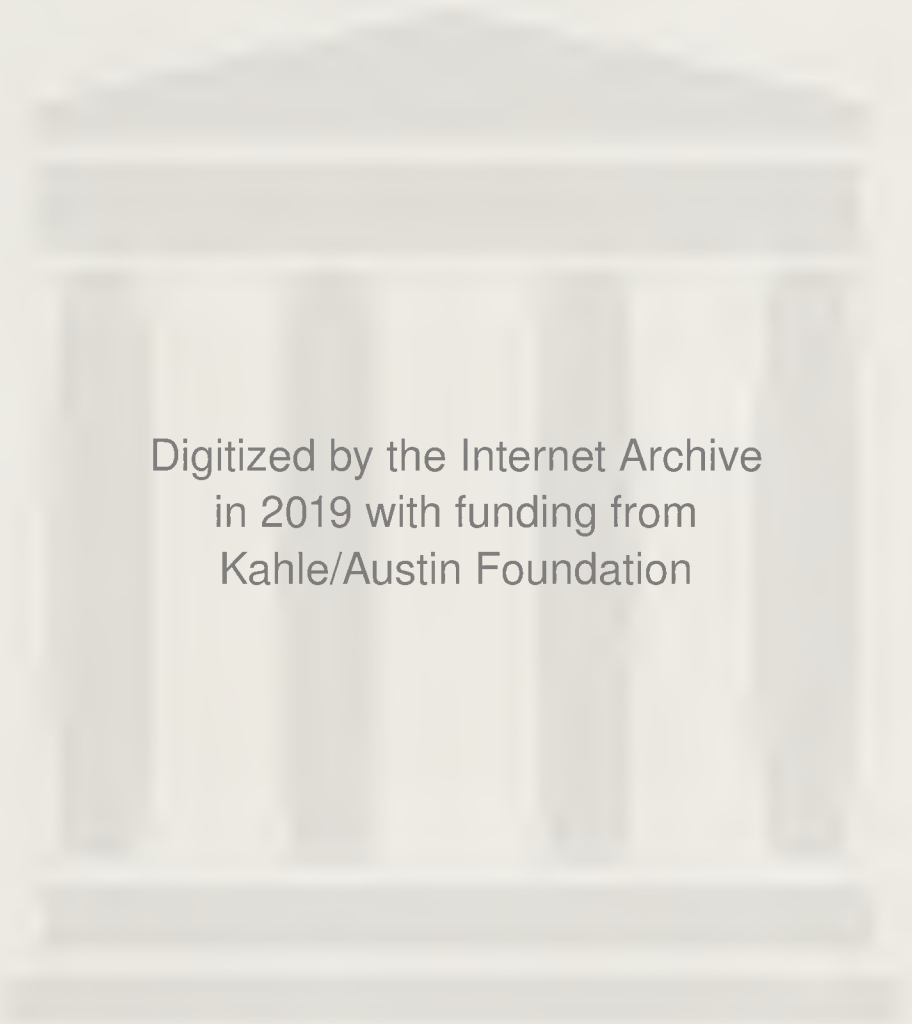
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THIRD CONFERENCE

on the

MEDICAL SERVICES IN CANADA

arranged by the

CANADIAN MEDICAL ASSOCIATION

and held under the patronage of

THE HONOURABLE JAMES H. KING, M.D., M.P.
MINISTER OF PENSIONS AND NATIONAL HEALTH FOR CANADA

in the

HOUSE OF COMMONS, OTTAWA

on NOVEMBER 21 *and* 22

1929

ALFRED T. BAZIN, D.S.O., M.D., C.M., *Chairman*
T. C. ROUTLEY, M.B., *Secretary*

OTTAWA
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Name	*Address*	*Body Represented*
Agnew, Dr. G. Harvey	Toronto, Ont.	Canadian Medical Association.
Almon, Dr. W. Bruce	Halifax, N.S.	
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Anderson, Dr. W. G.	Wardlow, Alta.	Coll. of Phyns. and Surgeons of Alberta.
Argue, Dr. John F.	Ottawa, Ont.	Medical Council of Canada.
Austin, Dr. J. L.	Kingston, Ont.	Queens University.
Baker, Dr. J. O.	Edmonton, Alta.	
Bates, Dr. Gordon.	Toronto, Ont.	Canadian Social Hygiene Council.
Bazin, Dr. A. T.	Montreal, P.Q.	Canadian Medical Association.
Bélisle, Dr. J. R.	Hull, P.Q.	P.Q. Medical Association.
Benoit, Dr. E. P.	Montreal, P.Q.	University of Montreal.
Biggar, Dr. J. L.	Toronto, Ont.	Canadian Red Cross Society.
Boardman, Dr. E. J.	Winnipeg, Man.	Manitoba Medical Association.
Bourgeois, Dr. B. G.	Montreal, P.Q.	
Bow, Dr. Malcolm R.	Edmonton, Alta.	Alta. Prov. Department of Public Health
Brodie, Dr. G. M.	Woodstock, Ont.	Ontario Medical Council.
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Collier, Dr. Louise A.	Ottawa, Ont.	Canadian Medical Association.
Creelman, Dr. P. A.	Charlottetown, P.E.I.	Prov. Department of Health, P.E.I.
Cross, Dr. C. Ernest.	Three Rivers, P.Q.	Prov. of Quebec Medical Association.
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Fenwick, Dr. Charles P.	Toronto, Ont.	Canadian Social Hygiene Council.
Ferguson, Dr. John.	Toronto, Ont.	Ontario Medical Association.
Fitzgerald, Dr. J. G.	Toronto, Ont.	Ontario Medical Association.
Fleming, Dr. A. Grant.	Montreal, P.Q.	McGill University.
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Hale, Dr. George C.	London, Ont.	University of Western Ontario.
Hamilton, Dr. T. G.	Winnipeg, Man.	Manitoba Medical Assocaition.
Harris, Dr. Norman MacL.	Ottawa, Ont.	Can. Public Health Association.
Harwood, Dr. de Lotbinière	Montreal, P.Q.	University of Montreal.
Heagerty, Dr. J. J.	Ottawa, Ont.	Dept. Pensions and National Health.
Howden, J. P. (M.P).	Ottawa, Ont.	
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MacKenzie, Dr. Kenneth A.	Halifax, N.S.	Medical Society of Nova Scotia.
MacMurchy, Dr. Helen.	Ottawa, Ont.	Dept. Pensions and National Health.
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McEachern, Dr. J. S.	Calgary, Alta.	Alberta Medical Association.
McGanity, Dr. A. J.	Kitchener, Ont.	Ontario Medical Association.
McKenty, Dr. James	Winnipeg, Man.	
McPhedran, Dr. Harris.	Toronto, Ont.	Ontario Medical Association.
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Middleton, Dr. F. C.	Regina, Sask.	Saskatchewan Dept. of Public Health.
Millar, Dr. Ross.	Ottawa, Ont.	Dept. Pensions and National Health.
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Routley, Dr. Fred W.	Toronto, Ont.	Red Cross Society.
Routley, Dr. T. C.	Toronto, Ont.	Canadian Medical Association.
Ryerson, Dr. E. Stanley.	Toronto, Ont.	University of Toronto.
Simmons, Dr. G. A.	Ottawa, Ont.	
Simpson, Dr. J. C.	Montreal, P.Q.	McGill University.
Spankie, Dr. Wm.	Wolfe Island, Ont.	Medical Council of Canada.
Stevenson, Dr. James.	Quebec, P.Q.	P.Q. Medical Association.
Trottier, Dr. E.	Montreal, P.Q.	P.Q. Medical Association.
Van Wort, Dr. G. C.	Fredericton, N.B.	College of Physicians and Surgeons, N.B.
Veniot, Dr. C. J.	Bathurst, N.B.	N.B. Medical Society.
Walker, Dr. S. L.	Halifax, N.S.	Medical Society of Nova Scotia.
Warwick, Dr. William.	St. John, N.B.	N.B. Department of Health.
Wilson, Dr. W. A.	Edmonton, Alta.	Alberta Medical Association.
Wodehouse, Dr. R. E.	Ottawa, Ont.	Canadian Tuberculosis Association.
Woolner, Dr. Ward.	Ayr, Ont.	Ontario Medical Association.
Young, Dr. A. MacG.	Saskatoon, Sask.	Coll. of Physicians and Surgeons of Sask. / Saskatchewan Medical Association.
Young, Dr. George S.	Toronto, Ont.	Canadian Medical Association.
Young, Hon. Dr. H. E.	Victoria, B.C.	B.C. Department of Health.

MEDICAL SERVICES IN CANADA

The Third Conference on the Medical Services in Canada arranged by the Canadian Medical Association met in the House of Commons at Ottawa on November 21 and 22, 1929, under the chairmanship of Dr. Alfred T. Bazin.

The CHAIRMAN (Dr. ALFRED T. BAZIN): Gentlemen, on behalf of the Canadian Medical Association I give you a cordial welcome. The roll-call is the first item of business. We come from all parts of Canada and it is very desirable, if not essential, that we should know each other as we meet and listen to each other discussing the questions on the agenda. So I will ask each one of you to rise in turn and in a distinct voice give his name, his residence, and the organization with which he is associated; in other words, whether he is here because he is on a licensing board or a teaching body, or representing public health, or practising medicine.

(A roll-call was here taken—see registration.)

The CHAIRMAN: You see, ladies and gentlemen, we have a very good attendance and a good representation from many interests. I will now ask the secretary, Dr. T. C. Routley, to make some important announcements.

Dr. T. C. ROUTLEY (Toronto): Mr. Chairman and members of conference, I have been asked to read to you a telegram received this morning from the Hon. J. H. King, Minister of National Health for Canada, the message coming from Golden, B.C. It is addressed to me as secretary of the Canadian Medical Association:—

"When plans were submitted for date your conference it was expected that Prime Minister King's western tour would have been completed in time to permit my being present with you. However, the arrival of Mr. Ramsay MacDonald, Prime Minister of Great Britain, delayed Mr. King's trip and consequently delayed my return to Ottawa. I would like the president to express my sincerest regrets to the conference as well as my great disappointment at my inability to be present and assure them of my desire as Minister of National Health and as a member of the profession to co-operate in every way possible to advance health measures throughout Canada.

"I believe it is your purpose to organize the Royal Canadian College of Physicians and Surgeons under legislation passed at the last session of Parliament. I am in fullest sympathy with this movement and its objects. It is another step in Canadian progress. There is no class of men in Canada more closely in touch with Canadian home life and the ideals of our people than those engaged in the medical profession.

"I wish also to thank the profession for their helpful co-operation in dealing with Canada's greatest social problem; that is, the care and treatment of those who served overseas and their dependents.

"(Signed) J. H. KING."

I desire at this time, Mr. Chairman, to direct the attention of the conference to the dinner which will be held to-night at the Chateau Laurier. The hour of the dinner is set down in the program as seven o'clock. That has been changed to 7.30 p.m. in order that we may meet the convenience of the distinguished speaker of the evening, Prof. Stephen Leacock of Montreal. It is unnecessary for me to make any reference to Professor Leacock other than to mention his name, to assure that a very rare treat is in store for us to-night. As the hotel management is anxious to know as soon as possible how many covers to lay for the dinner, the price of which is $2.50, I should be very glad if those present who purpose attending would stand in order that I can communicate the number to the hotel.

I may add that not only will members of this conference be very welcome at this dinner, but others who are their guests. We also extend a hearty invitation to the medical profession of the city of Ottawa. (Members then stood.)

It would appear that about sixty have signified their intention of being present. As others will be attending the conference during the day, I think it will be safe for us to count on an attendance of seventy-five. You will please buy your tickets at the cashier's desk in the hotel.

I am further instructed to advise you that the proceedings of this conference are being reported by members of the Hansard staff. Papers and discussions will be recorded in detail, so that anything you may say can be held for or against you at the conclusion of the conference. (Laughter.) It is most important that all members of the conference when rising to speak preface their remarks, in a clear voice, by giving their name and address, as our reporters find it very difficult to trace these remarks unless that is done. The proceedings will be printed in book form and distributed through the courtesy and generosity of the Department of Pensions and National Health of Canada, and for this we are particularly grateful to the Honourable Minister, Dr. King, and to his Deputy, Dr. John A. Amyot.

The press of Canada is here as usual and is welcome. We ask them, however, to co-operate with us in giving to the public an accurate account of our deliberations and to that end we particularly ask them to associate themselves with Dr. Grant Fleming who will be glad to assist them in having their notes transcribed in a form which the lay public of Canada will appreciate.

Mr. Chairman, it would be in order at this time for the meeting to instruct you to appoint two committees—others if you think necessary; but I particularly refer to a Program Committee and a Committee on Resolutions.

You have in your hands, ladies and gentlemen, printed agendas for this conference. Necessarily, this had to be a tentative program. Already it has come to my attention that other speakers are with us at this time whom I am sure you will be glad to hear before our proceedings conclude to-morrow. Any member present who desires to bring a communication before the conference would be advised to communicate with the chairman of the Program Committee if such is appointed.

The CHAIRMAN: I am prepared to receive resolutions appointing these two committees.

It was moved by Dr. POOLE, seconded by Dr. WALKER, and carried, that the chairman appoint the committees.

The CHAIRMAN: The chair will ask that he be allowed a certain latitude of time before announcing the personnel.

We regret, of course, that the Minister of Pensions and National Health, the Hon. Dr. King, is unable to be with us to-day. We regret it, not because he is the Minister of Health so much as because he is a member of the medical profession, and would not only be greatly interested but would have undoubtedly taken part in the deliberations of this conference. But we are pleased to announce to you that the Hon. Mr. Elliott, Minister of Public Works, is here to present to us greetings and words of welcome on behalf of the Government.

The Hon. J. C. ELLIOTT (Minister of Public Works): Mr. Chairman, ladies and gentlemen, I am sure that it is a matter of great disappointment to you to hear that my colleague, the Minister of Pensions and National Health, has found it impossible to be present on this occasion. I think most of you, particularly those of you who have been associated with him in the medical profession, knowing him as you do, will realize something of the extreme regret that it is to him to be unable to be with you at this time. He wired me asking

if I would be good enough to represent him here and to say how much he regrets his inability to be present, and how thoroughly he is in sympathy with the work which the various organizations here represented are doing.

It is unnecessary for me to recall the great number of important associations which are here represented. I had an opportunity of glancing over the list of Dominion, provincial and the various other associations and I also read the list of the delegates present, and I want to express to you, Mr. Chairman, the great pleasure that it is to me to have the opportunity of looking into the faces, and of saying just a few words of welcome to the leaders in the work of the medical profession, who have been sufficiently interested in the advancement of that profession to leave their very pressing duties and come here and devote some of their valuable time to this great work.

As a former Minister of Health I know something of the objects which are the aims of this conference. It was a distinct advance when in 1924 the first meeting was held and the objects of the various associations there represented were set forth with a view to promoting as far as possible those various aims.

May I express on behalf of the Government generally and of my esteemed colleague, the Minister of Pensions and National Halth, particularly, our appreciation of the benefits which are resulting from the discussions which took place at the conference in 1924 and also the second conference in 1927.

Health is primarily within the jurisdiction of the provinces and I think the boards of health and the various other health organizations of the provinces are represented here. At the time that I was privileged to do something in connection with the Health Department it seemed to me that there was a great work which the Dominion Department of Health could perform in keeping in touch and in co-operating as closely as possible with the representatives of the various provinces and obtaining from them the results of their experiences in the various branches of health work. The collection and dissemination of those views and opinions, and of such statistics and other information as were received from those various provincial organizations appeared to be important functions which the Dominion Department of Health could perform.

We all agree as to the great functions being performed by those engaged in looking after the health of crops and animals and generally the things that tend to advance the material progress and development of this great young country. Important as is anything that can be done by my revered colleague, the Minister of Agriculture, to improve the health of the various animals on the farms, to improve the health of the various crops in the fields, there is nothing so important to this country as the health of that great body of people who constitute the Canadian nation. To that work you, ladies and gentlemen, are making a great contribution. May I repeat how thoroughly in sympathy with your aims and your objects are the minister and the various other officials of the Department of Health, and I can assure you that everything that lies in their power will be done to assist in your great work. I trust that the deliberations of this conference will be of equal or of greater value than those of either of the previous conferences; that you will have an enjoyable sojourn here and that your endeavours will continue to produce the useful and important results which I know are the aims of everybody interested in this work.

I am sure it is not your desire to have me attempt to deliver the address which Hon. Dr. King would have delivered to you if he were present. I feel that I should not occupy your time further except to express on behalf of the Minister of Health and the other members of the Government the heartiest possible welcome. I trust that before you disperse I may have the opportunity

of meeting you individually and collectively and discussing with you our common problems. Ladies and gentlemen, may your efforts be crowned with success.

Dr. J. A. Amyot (Deputy Minister, Department of Pensions and National Health): The Hon. the Minister, ladies and gentlemen; as I know you are restricted for time, I will not presume to take up any more of it than is actually required to fulfil my small function. You have at heart the interest of public health, the interests of the profession and the interests of the work that the Department of National Health is doing. I will restrict myself to two subjects: one, the eternal narcotic question—just a few words—and then, the way we cross a little with the medical profession in the treatment of sick mariners. I will merely state the facts in both connections and leave it at that.

The Narcotic Question.—The late Dr. Clark, on being reproached by a medical man for the intricacies of the Act, said in reply: "Practice legitimate medicine and you will not need to know that there ever was a Narcotic Act." I would like to emphasize his expression. The essential fact of the Act, in so far as the practitioner is concerned, is this. You must not prescribe or give to one addicted to narcotic drugs "any drug" for self-administration; that means any narcotic drug in the Act. In other words, you must not give him something to take away with him and use over that day or the next week. So far as other sick are concerned, anything from which they are suffering that requires narcotics, you need never ask the department about at all. The Act does not interfere with your legitimate work one bit, but we would ask you, for the sake of the public and for God's sake, not to administer narcotics unless there is absolute necessity, because of the consequences that may follow.

We have in Canada, unfortunately, a large number of narcotic addicts (8,000 probably). Six thousand of these have reached the "underworld" and are just about lost. Two thousand are still in the "upper stratum," but will eventually gravitate to the "underworld," unless they are stayed on their downward course. One thing must be kept in mind when administering narcotics, it is that we are running the risk of putting more into the addict class. There is fair hope of curing these "two thousand," because of more or less favourable surroundings and circumstances after the doctor has, by treatment, taken away the "withdrawal symptoms." The psychiatrist and the grace of God must persuade them then that they must, for their own good, never use the drug again. Some cynics would say "that is the rub," but it has been done and frequently, but hardly ever in the "underworld."

The treatment of these people is a charge on the provinces as is the treatment of their indigent sick, insane and inebriates. The treatment of the six thousand is in prisons or in institutions. For the two thousand, it is best done in special wards of general hospitals, thus avoiding stigma, which is very important as can well be appreciated. There was a time when general hospitals would not treat the tuberculous or the venereal. Receiving funds from the provinces should be conditional on their treating addicts as well. The provinces will avoid the large unnecessary expenditure of capital by requiring designated general hospitals receiving public aid to treat addicts towards their cure.

Addicts can be cured, especially those who have proper homes to go to after their "withdrawal symptoms" have been removed. There is a technique to be followed. The treatment does not merely consist in the withholding of the drug of addiction. Symptoms arising out of withdrawal have to be met and can be successfully. The patient can be put in the state that does not any longer demand the drug of addiction. He has then to be persuaded that, for the sake of his future, he must not put himself again in the state of temptation. Those who have not got to the underworld are still capable of being so persuaded. The

department knows of several cases that have remained cured. It is another thing with the "underworld case." There is very little chance for him. For the good of the public, he should be locked up. Addicts rarely reach old age, but the aged can be cured and, in Britain, have been treated successfully and cured.

There is one other point I wish to mention. At the present time, with the exception of two provinces, hospitals have not the power to hold addicts for treatment. With very little addition to laws already existing for the holding of irresponsibles, addicts to narcotic drugs can be included.

It is for physicians, therefore, to plead, with the appropriate authorities, each in his own province, for hospital wards wherein to treat these two thousand for whom there is yet hope to keep them from the underworld and rehabilitate them. It is for us to learn the technique of treatment and for the province to give power to hold the addict for treatment until results are obtained.

Now, the other subject is that of sick mariners and, in order that there may be no misunderstanding at all, what I want to say with reference to this I have had written down, and if you will bear with me I will read it. (Reads.) Prior to Confederation, the medical treatment and care of sailors was unorganized and was, therefore, somewhat haphazard in nature. We find, in the year 1822, that the Provincial Legislature of New Brunswick voted the sum of £500 for the establishment of a Marine Hospital and pest-house, and the city of St. John provided land for the erection of the marine hospital. This institution was in existence until the year 1893, when it became a home for incurables.

At the time of the passing of the British North America Act, it was decided that inasmuch as the Dominion was granted the privilege of collecting taxes, quarantine and the establishment and maintenance of marine hospitals should become a function of the Dominion Government. In 1867, therefore, sick mariners came under the care of the Dominion; and, in order to provide funds, a duty was levied on ships entering Canada, and Part V of the Canada Shipping Act, which relates to sick and distressed mariners, was passed. If we refer to that section of the Act which deals with duty on ships we find that there shall be levied and collected on every ship arriving in any port in the provinces of Quebec, Nova Scotia, New Brunswick, Prince Edward Island or British Columbia, hereinafter called "the provinces," a duty of two cents for every ton which such ship measures, registered tonnage, but in no case shall the duty payable by any ship be less than two dollars in any year.

No ship otherwise liable to pay the duty shall be exempt from the payment of the said duty by reason of her voyage being one not requiring entry or clearance at the Custom House. If the ship does not require entry, the duty shall be paid immediately on her arrival. No ship engaged in the coasting trade of Canada and arriving at any port in any of the said provinces from any other port in the same province, or arriving at any port in the province of Quebec from any port in the province of Ontario, shall be subject to payment of the said duty. No ship arriving at any port in Canada from any place out of Canada, and afterwards continuing her voyage to another port in Canada, shall be exempt from the payment of the said duty at the last mentioned port, unless she has paid it at the first mentioned or some other port on the same voyage.

Such duty shall be payable on each ship each time she arrives in any such port, but in no case shall it be oftener than three times during each calendar year, and shall be paid by the master or person in command of such ship, or by some person on his behalf, to the collector or other chief officer of the customs at the port at which such ship is entered, and at the time of making such entry. Such entry shall contain on its face the tonnage of such ship.

Except as in this part mentioned, no entry shall be validly made, or have any legal effect whatsoever, unless the duty is so paid. No collector or other chief

officer of the customs shall grant a clearance to any ship on which such duty or any part thereof is due or unpaid. Although the above provisions did not originally apply to fishing vessels, at a later date an arrangement was made by which the captain of a fishing vessel had the privilege of paying the duty and enjoying all the benefits of the Act. The master or person in command of any ship paying such duty may send to any hospital for sick mariners, at any hour of the day, and, in the case of accidents or emergency, at any hour of the night, any sick mariner belonging to the ship.

Such a sick mariner so sent with a written recommendation from such master or person in command of such ship, endorsed as approved by the collector of customs at the port, or other officer appointed for the purpose by the minister, shall be gratuitously received into such hospital, and receive therein such medical and surgical attendance and such other treatment as the case requires.

No sick mariner shall be entitled to the benefits conferred by this section of the Act for a period longer than one year without written authority from the minister, and no sick mariner shall be entitled to treatment or care hereunder when suffering from permanent insanity.

The funds collected for the treatment of sick mariners are paid into the consolidated revenue of the country, and when Parliament meets a sum sufficient for the treatment of sick mariners is voted by the Government. This money is turned over to the Department of Pensions and National Health to be used for the treatment and care of sick and distressed mariners.

From the year 1867 until 1921, the dues were $1\frac{1}{2}$ cents per ton. It was found necessary in the latter year to increase the dues to 2 cents per ton, as the expenditure was greater than the revenue. In spite of the increase in the rate we have again reached a point where the expenditure is greater than the revenue.

Each sailor who is a member of the crew of a ship which has paid dues is entitled to treatment when ill, irrespective of the nature or severity of the illness. Treatment is provided in government hospitals, general hospitals, infectious disease hospitals, sanitoria, nursing homes and private homes if hospital accommodation is not available.

The Department of Pensions and National Health has two marine hospitals for the treatment of sailors, one of which is situated at Sydney, N.S., and the other at Lunenburg, N.S. In addition, sailors are placed in some of the departmental hospitals, which are set aside for the treatment of soldiers, when conditions permit.

Contracts have been entered into by the Department of Pensions and National Health with various hospitals, which number fifty-eight, whereby a sailor is given complete hospitalization for a definite per diem rate. In the case of General hospitals, this is at the rate of $3 per day. Infectious disease hospitals vary from $3.50 to $5 per day. In sanitoria the rate is $3.50 per day. In hospitals at which there is no attending physician the rate is $2.50 per day. Outdoor treatment is provided at the same rate as indoor treatment. For example, if a sailor has a headache and goes to the outdoor where he receives a pill, the charge is the same as if he occupied a bed in a ward for twenty-four hours.

General hospitals, sanitoria and infectious disease hospitals agree to furnish the sailor with ordinary public ward quarters, hospital bedding, linen and clothing, full medical and surgical care, necessary operations, including use of operating room, anaesthetics, X-ray, dressings, hospital appliances, etc., satisfactory diet and medicines, including serums and vaccines. Hospitals in which there is no medical attendant supply all but the services of the physician.

In outlying districts where hospitals are not available, a room is found for the sick sailor, generally at the rate of $1 per day, and board, nursing, medical

or surgical treatment provided. It has been found necessary in some districts to appoint physicians on a salary basis, and in some others, on a fee basis. There are fifty-seven physicians on salary and forty-eight physicians on a fee basis. The salary is based upon the amount of work performed. The fees of physicians who are on a fee basis are as follows:—

First visit aboard ship, at home or hospital, etc	$ 2 50
Subsequent visits aboard ship, at home, hospital, etc	1 50
First attendance at office	2 00
Subsequent attendance at office	1 00

An additional 50 cents per visit or attendance may be allowed if it was during night hours (8 p.m. to 6 a.m.).

30 cents a mile, one way, may be allowed for the distance travelled outside the town or city limits during day hours (6 a.m. to 8 p.m.) and 50 cents per mile, one way, during night hours.

The total number of sick, distressed and injured mariners treated during the year 1927-28 was 5,217, and the number of days of hospital treatment was 45,207.

A tabulated statement of disease and injuries treated during the year 1927-28 will be found in the Annual Report of the Department of Health for that year. From year to year we find that the number of cases being treated is increasing, and the demand for hospital medical services is becoming more and more imperative.

We have practically reached a limit now. The Dominion Government is spending more than it is receiving at the present time, and the already burdened shipping interests have to be met again for an increased rate. It is because of the increased costs and the greater number of sailors that are being treated. I thought it well to mention this because it is of some interest to you. I am glad to have been able to make this brief statement of the situation so far as sick mariners are concerned.

Dr. Middleton: With regard to the practice of prescribing narcotics, as it affects the general practitioner, Dr. Amyot made a statement which is not very clear to me, and which I am sure would be no clearer to the general practitioner in the province from which I come. The statement, if I understood it correctly, was that the practitioner might prescribe narcotic drugs to any patient except an addict. Is that correct?

Dr. Amyot: Yes; that is what is required by law.

Dr. Middleton: I am sure that in our province the general practitioner does not know what the law is in this regard, nor do the druggists nor the officers who enforce the law. I know that druggists will not supply narcotics to, for example, a dying Catholic. Physicians from towns outside Regina, and from outlying districts, have asked me to have forwarded, to patients many miles away—to a cancerous patient perhaps—a drug in sufficient quantity to obviate travelling every day a distance of ten, twelve or fifteen miles for the purpose of obtaining one dose. I have been instructed by the Mounted Police officials in Regina that such a patient may be supplied with only one dose at a time. I should like to know how true that is. Suppose a patient is being given morphine—a half grain, or a grain, as the case may be.

Dr. Amyot: Or twenty.

Dr. Middleton: Yes, or twenty, daily. Under the law as it stands, may sufficient morphine be sent to that patient to keep him or her supplied for three or four days, or a week, provided there is some one in the house with sufficient intelligence to administer the regulation dose day by day?

Dr. Amyot: I do not know where the idea of one dose comes from; it is a misunderstanding of the law. Under the law a doctor has the right to prescribe morphia for a patient, and in his prescription he is not limited to half a grain, or ten grains or fifty grains. He is required to sign his name for it, and a

sufficient quantity may be sent to the patient, under the supervision of some one who shall be responsible for its administration, and that quantity may be enough to supply the patient's needs for a week or ten days. There is no objection whatever to such a practice. But the point is that no one may go back to the druggist and have that same prescription repeated. The doctor must make out a new prescription each time he goes to the druggist. The intention is to make the doctor responsible for each prescription filled. That is all. But there is nothing to prevent the ordinary practitioner from prescribing sufficient to supply the needs of his patient. The druggist is also responsible for every quantity supplied, in that he must have the doctor's signature every time; he must be able to say, in regard to each prescription, "This prescription comes from Dr. So and So, because I know his signature." He cannot escape responsibility by claiming ignorance of the doctor's signature. If he fills a prescription improperly attested to he may be prosecuted under the law. He is required to watch that carefully, because there are a good many people around forging prescriptions.

The CHAIRMAN: It is important that this matter be thoroughly understood, and this is the time to have questions asked and answered. We have representatives from the different medical associations. Almost every province is represented, and these representatives can go back to their respective provinces and clear up any dubious points in the minds of the members of the profession at large. It will be remembered that the department issued to every member of the profession in Canada—at any rate, it reached me—a copy of the Act, with the regulations thereunder, together with a covering letter which I thought very clear and rather sympathetic, recognizing, as it did, that a great many members of the medical profession would not find the time to read the entire Act. More than that, they would be lost in a maze of legal technical phraseology, and this covering letter made it quite clear and distinct just what the law was as it applied to the profession. It clearly set out what the medical profession might or might not do in the prescribing of narcotic drugs, and, in detail, the method by which a prescription should be written and registered, and the repetition of that prescription taken care of. If there is any doubt in any one's mind as to the details of the application of that law, this is the time to have Dr. Amyot clear it up satisfactorily. Is there any further discussion?

Dr. HOWDEN: I am not a delegate and therefor cannot speak authoritatively. But I had the privilege of sitting in committee in the House of Commons last spring when the Act was under review, and so I happen to know something about it. Unfortunately, I have a very poor memory; but as I recall the discussion, one of the points that caused considerable difficulty was with regard to the mailing of narcotic drugs. I know that in the case of illicit transportation of drugs the mails are searched from time to time, and there are certain regulations that must be observed when mailing quantities of narcotic drugs from one station to another. I must confess that my mind is hazy on the subject. I should like to hear—and I think it quite necessary that we should have—a recital from Dr. Amyot of what precautions are called for, and what steps are required to be taken in the mailing of drugs.

Dr. AMYOT: In shipping drugs from one place to another the registered mail is used, or the drugs may be expressed.

Dr. BOARDMAN: Dr. Amyot made a slight geographical error which I think it just as well to correct; I should not care to have such a misapprehension prevail. We have a wonderful map before us, and Fort Nelson is *not* in Ontario. I wish to have it understood by the members of this body that Fort Nelson is in Manitoba, as is also Fort Churchill; and it is in Manitoba and not in Ontario that the maritime problem lies. Dr. Amyot stated, I believe, that there were 45,000 hospital beds. I am not sure about the figures, but the question is this:

Are these hospitals selling medical services, or are they not? The hospitals are receiving $3 per day for the care of sick mariners: just what does the doctor receive for the treatment of these patients? That was not clearly stated.

Dr. Amyot: When we administer this Act—as it has come to us to administer—we have to forget for the time being that we are doctors; we are business people, and we must administer the Act accordingly. The money is given to us for a specific purpose. We go to the hospital and make arrangements for the treatment of patients, and the hospital gives a rate; and that having been done, we are through. As to the basis on which the hospital shall pay the doctor, whether it pays him in cash or gives him a quid pro quo in the advantage he derives from association with the institution,—that is not our concern: it is a business proposition so far as we are concerned. We have to administer certain money handed to us for the treatment of sick mariners. We might hand it over to an absolute layman and say, "You look after this." The mere fact that I, who happen to be at the head of the department under the minister, am a doctor means nothing; the man who is looking after the business end of the matter need not be a doctor at all. His business is to make arrangements with the hospital, and once the hospital undertakes to provide certain treatment for patients, and to give them medical and surgical care, it is no concern of ours afterwards as to how they shall remunerate the doctors.

Dr. Fred W. Routley: You will find that most of the workmen's compensation boards in Canada do not include medical treatment in hospital care, so that if the Dominion Government wished to find a precedent for absolutely separating hospital care and medical treatment it could find that precedent in the working of the various workmen's compensation acts, which differentiate, paying the medical profession for the treatment they give patients, and compensating the hospitals on a cost basis. I wish to refer to one or two other phases of the question which Dr. Amyot brought up. First of all, to the question of general hospitals taking care of narcotic cases. I agree with Dr. Amyot that probably the proper place for the care of narcotic drug addicts is the general hospital. The general hospitals of the country are faced to-day with, I should say, three major problems along this line: first, the care of the narcotic addict; secondly, the care of the patient suffering from tuberculosis; and, thirdly, the care of early mental cases. Now I submit that, at the present time, the general hospitals of Canada are not equipped to care for these types of patients; they lack the necessary equipment, on the basis of the government and municipal support which they are at present receiving. It is true, on the face of it, that the general hospital is expected to receive all kinds of cases because it gets certain public funds. But analyse hospital costs, and you will find that practically all the hospitals in Canada are conducted almost entirely on a voluntary basis so far as finances are concerned—or rather, I should say, on a self-supporting basis. They receive from $1.75 to $2.50 per day for the care of patients who come within their walls, while the actiual cost of the care of these patients will run up to $5 and more a day, if all costs are taken into consideration. I am not opposed to the hospitals taking these cases. But I submit—and this is probably the appropriate time and place to raise the point—that if voluntary hospitals, such as practically all the hospitals in Canada are at the present time, are going to be asked to care for an unusual type of patient, particularly the narcotic addict, who requires very special treatment, and early mental cases as well, then these hospitals will be faced with a grave problem. And the same remark applies to patients suffering from tuberculosis. It is a serious matter. If we receive a tuberculosis case we may have to keep it six months, and we receive no remuneration, or practically no remuneration, for the patient after 120 days. We get the ordinary statutory grant of $1.75 a day for the first 120 days, and thereafter 10 cents a day.

I feel that the hospitals are suffering to-day because of lack of understanding, on the part of governments and municipalities, of their conditions and their needs; it is not fully appreciated just what funds are necessary to maintain these institutions. The monies required for the equipment and support of the hospitals in Canada come for the most part from the pockets of the people, and the hospitals are unanimously of the opinion that the current cost of indigent patients should be borne by the municipality, or jointly by the municipality and the provincial government; or, in the case of Indians and mariners, by the Dominion government.

I just wish this conference to appreciate the feeling of the hospitals, which I believe I, for one, understand thoroughly.

Dr. John Ferguson (Toronto): As representing the Ontario Medical Association and also the Ontario Hospital Association, I wish to make just two points, one of which is with reference to narcotic addicts. It is the law in the province of Ontario—and I presume this is true of practically every other province—that a person committed to an asylum for mental trouble may be held in that institution during such time as the medical authorities deem it wise to detain him or her. So far as narcotic addicts are concerned, if any headway is to be made it can be made only on condition that adequate authority be given the institution. On that point I heartily endorse what Dr. Amyot has said, and I think every one here should support that view.

Properly considered, a narcotic addict is a sick person, just as much as any one who is insane, and he should be so regarded. The general hospitals throughout any province would be the nearest places where such addicts could be treated; and in my opinion it is quite within reason to expect that medical practitioners attending the sick and injured in these various hospitals should fairly well familiarize themselves with the best methods of handling the person addicted to any narcotic drug.

What, then, would be essential to success in this matter would be the legal right of the hospital to keep such an addict within the institution until such time as the physician in charge of that case might think it advisable to have him under supervision; otherwise the whole thing would be a complete failure.

The other point I wish to discuss very briefly is the treatment and care of sick mariners. These people come to various ports from almost all points of the compass. What I wish to emphasize is this—and I hope that all here will see the justice of it: that the Department of Health should so dispose of the revenues collected from vessels, whose sailors are liable to sickness at any time, as to provide for hospital charges, nursing, medicine, and so forth, and an additional sum which would pay the members of the profession such minimum fee as might be considered reasonable in the light of the workmen's compensation acts in the various provinces.

Dr. McGanity: There are two points I wish to touch upon as affecting the practitioner in the larger city. Those of you who receive visits from agents are aware that, in ordering certain medicines which contain narcotics, the doctor is required to sign, and sometimes to fill out, a particular form. His signature is written at the bottom of the form, and, so far as narcotics are concerned, the form could be made out to meet all the requirements of the Dominion for a month. If that form is approved by the department it should, I think, be so altered as to make it clear that no quantity of any drug, greater than is called for, is signed for. That is the first point. And the second is this. Those of you who have read the second last British Medical Journal will remember that a resolution was passed unanimously by a recent conference of practitioners over there to the effect that the next occasion on which the British Government might commit itself in the League of Nations, in the matter of prohibiting the

use of certain drugs, it should first consult the medical profession of Great Britain. What they had reference to particularly was the use of heroin. May I ask Dr. Amyot whether the Dominion of Canada, through the League of Nations, has committed itself to the principle of prohibiting the use of this drug?

Dr. Amyot: Heroin is of course the archfiend among the opium derivatives. The only country that does not permit the manufacture of heroin within its borders is the United States; neither cocaine nor heroin is allowed to be manufactured there. It may be imported for certain purposes; but in none of the public services—the Marine, the Navy, the Army, in the city of New York, in Chicago, in any hospital supported by public funds—is either heroin or cocaine allowed in the treatment of patients. The American Medical Association decided by vote that they could do without it and recommended against its use. They have not been able to bring about a similar situation in Europe, and I am afraid they do not realize at all that they have a narcotic problem. Mr. Sharman, Chief of the Narcotic Division, who was in England a short time ago, was informed that there were no drug addicts in the Old Country; and Queen Victoria, forty years ago, said they had no prostitutes there. They do not realize the situation at all. On the continent there are still doctors who would say that heroin is possessed of so much virtue that you could not do without it. The patient would never discern the difference, but to some medical minds there would be a vast difference. So that there is not much hope of stopping the use of heroin in Europe. We in this country, however, having canvassed our hospitals and various bodies to ascertain whether they would forego the use of heroin and cocaine, have received a unanimous reply in the affirmative, with the exception of the Toronto General Hospital and the Montreal General. The reason given in both these cases was that heroin was so much more valuable in the treatment of certain conditions in pregnancy. That is the situation so far as heroin is concerned.

So far as agents are concerned, if one of these gentlemen came to you and wanted to sell you some stock, I should think you would be more careful about signing your name to an order form than you would in the case of a prescription for a narcotic. And, indeed, you ought to be as careful with that as with the other. These agents are go-getters, every one of them, and will slip anything over if they can.

The Chairman: I shall at this point announce the personnel of the two committees to which you have agreed:—

Committee on Resolutions.—Chairman, Dr. H. E. Young, Victoria, B.C.; Secretary, Dr. G. Harvey Agnew, Toronto, Ont.; Drs. J. G. McEachern, Calgary, Alta.; A. MacG. Young, Saskatoon, Sask.; E. J. Boardman, Winnipeg, Man.; C. J. Veniot, Bathurst, N.B.; P.A. Creelman, Charlotetown, P.E.I.; S. L. Walker, Halifax, N.S.; P. C. Dagneau, Quebec, P.Q.; John Ferguson, Toronto, Ont.

Program Committee.—Chairman, Dr. Kenneth A. MacKenzie, Halifax, N.S.; Secretary, Dr. A. Grant Fleming, Montreal, Que.; Drs. G. C. VanWart, Fredericton, N.B.; B. G. Bourgeois, Montreal, P.Q.; Duncan Graham, Toronto, Ont.; W. G. Anderson, Wardlow, Alta.; D. S. Johnstone, Regina, Sask.; John S. Poole, Neepawa, Man.

Each of these committees has power to add to its numbers.

I will ask these two committees, at the end of this session, to meet for a few moments for the purpose of organization, and possibly they will be prepared, if they think it desirable, to make an announcement at the beginning of the afternoon session as to what procedure they are going to adopt.

Now, I am down on the program myself, but am not going to detain you much longer.

ADDRESS OF THE CHAIRMAN

We are met together in the Third Conference on the Medical Services in Canada, initiated and organized by the Canadian Medical Association with the desire to advance directly and indirectly the health interests of all the people of Canada.

It were well, at this stage, to pass in review the results accruing from the two preceding conferences and to determine anew what the future has in store.

These conferences are in no way executive, not even authoritative, except with that authority which well-informed and well-considered concerted opinion always exerts.

No individual here is necessarily cloaked with any official or delegated power from any organization. No expressed opinion is binding upon any organization.

As the title announces, this is a conference *on,* not *of,* the medical services in Canada.

At the conference of 1924, in the first flush of enthusiasm, a resolution was passed that "arrangements should be completed for the establishment of the conference upon a permanent annual basis."

At the second conference in 1927 (two and one-half years later) it was resolved to recommend "that these meetings be perpetuated at intervals to be decided upon by the Canadian Medical Association."

So here we are, and I would strongly recommend that careful study and consideration be given to the question of future conferences, by whom they should be organized, and at what intervals and by whom the agenda should be prepared.

In carefully perusing the reports I fail to find any criticism of the action of the Canadian Medical Association in initiating these conferences. But criticism there is, as it has been expressed to me as president, verbally.

Therefore, I repeat, the Canadian Medical Association requires a mandate.

For it is no light responsibility to call from distant parts of this far-flung country the representatives of organized medicine.

At the conference of 1924 it was resolved that the Canadian Medical Association be urged to secure funds with which to extend throughout all of Canada a system of Extra-mural Post Graduate instruction.

That this has been accomplished is a fact well known to all of you. But a summary of the four years' work just completed will be of interest, not only as regards grand totals but in comparing each year and noting the progress.

—	1926	1927	1928	1929	Total
Number of speakers	169	269	329	379	1,146
Number of addresses	513	729	802	730	2,774
Average attendance per lecture	29	27	31·7	36	.....
Total attendance	17,264	19,683	25,423	26,287	88,657
Total cost	$30,100 27	$28,831 66	$33,336 45	$31,257 21	$123,525 59
Cost per lecture per doctor	$1 74	$1 46	$1 31	$1 19	

The association will be very glad to get from you constructive criticism, and suggestions for improvement of this service.

In the proceedings of the 1927 conference the following matters were referred by resolution, or discussion, for study and action by the Canadian Medical Association, viz:—

(*a*) Nursing Education in Canada.
(*b*) Periodic Health Examination.
(*c*) Public Health Education.
(*d*) Hospital Service.

Of the first two we will receive detailed report according to our agenda.

Public Health Education

During the year 1928 this work was carried on by means of a weekly health article appearing in 173 newspapers published in the various provinces. The estimated total circulation, including six newspapers in the French language, was 1,350,919. The articles are supplied free. Numerous letters of inquiry have been received and replied to in the language of the correspondent.

The funds of the association were sufficient only for the clerical work entailed. The direction was undertaken voluntarily by Dr. Grant Fleming and an Advisory Committee.

But we are pleased to report that this demonstration brought active co-operation and support from the Public Health Committee of the Life Insurance Officers' Association of Canada and the department is now established on a firm basis with Dr. Fleming as a part-time associate secretary. Three hundred and thirty newspapers and magazines are now covered, over twenty being in the French language.

It is proposed to develop this department by adding to the newspaper activities, lectures and addresses on health, and offers to communities of health surveys.

Hospital Service

In January, 1929, by means of a grant from the Sun Life Assurance Company, this department was established with a full-time associate secretary.

The ultimate object is to assist, in every way, the provision of the best possible hospital service to every community in Canada, large or small.

Hospital associations have been promoted and fostered and many meetings have been organized in conjunction with those of medical associations.

An Advisory Committee, composed of trained hospital administrators throughout Canada, has guided the work of this department. Especial attention is given to the smaller hospital class.

I have referred above only to those matters delegated directly to the Canadian Medical Association, and have reported progress.

It would be presumption on my part to attempt to report as to what action other organized bodies had taken in reference to resolutions, recommendations or suggestions. I assume that speakers belonging to these organizations will, in the course of their remarks, acquaint this conference with the manner in which these suggestions have been officially received and what action has been taken thereon.

It would seem wise to constantly bring up for review the decisions adopted at former meetings of this body.

In concluding these brief remarks I wish to refer to the Honourable Minister of Health and his department.

In the two former conferences he was referred to as the patron of the conference.

At this third conference I desire to put him in his proper place.

True, we hasten to acknowledge his courtesy in providing for us this very suitable meeting place, the stenographic service, and, we hope, as in the past, the printing and distribution of the report of proceedings.

But the Minister of Health is far more than a patron, he is a participant in this conference, and a partner with the Canadian Medical Association in promoting health in Canada.

Through his appointed deputy he sits on the Council of the Canadian Medical Association and has full and equal privileges in discussion and direction of its affairs.

Surely this status is a matter for mutual congratulation.

Unless there is some announcement or statement of special importance to the conference to be made at this point, I think it would be wise to postpone further discussion until the afternoon session which will convene sharply at two o'clock.

MONDAY AFTERNOON SESSION

The conference resumed at 2 p.m., with Dr. Bazin in the chair.

The CHAIRMAN: This afternoon we are to have a discussion on the subject of

HEALTH AND THE STATE

This will be divided into two parts: first, from the preventive side, and, second, from the therapeutic side. We have a number of speakers on the program who have been asked to open this discussion. In addition, the Program Committee advises me that Dr. J. H. Elliott of Toronto has a communication which is cognate to the general theme, on the subject of tuberculosis. At the conclusion of the discussion we are to have a report from the Committee on Resolutions as to whether it has any special matter to introduce. I suppose we want to rise not later than five o'clock. Three hours of discussion is certainly as much as most people can intelligently undertake, either when in talking or in a listening position.

Now, it will be necessary, of course, for us to adopt some mode of procedure. At former conferences those who introduced a set paper have been allowed twenty minutes and those who discussed it five minutes each; then the one who presents the paper is allowed time of ten minutes in which to reply. Parliamentary procedure will be followed as far as the rules of debate are concerned, unless some important matter, in the opinion of this conference, is developed, in which case the chair will accept a resolution that the conference resolve itself into a committee of the whole.

The first subject, then, is "Health and the State"; first, from a preventive aspect, introduced by Dr. H. E. Young of Victoria.

(1) PREVENTION

Dr. H. E. YOUNG (Victoria, B.C.): Mr. Chairman and gentlemen, I did not expect to start the ball rolling, but I suppose this is because I come from the farthest point west and, in addition, the fact that British Columbia is at present engaged in an intensive study of this question with the idea of introducing it in the form of legislation in that province.

For the past six or eight years it has been a subject in British Columbia very much to the fore. It was introduced about that time at several meetings. Since then, various organizations have petitioned Parliament each year asking that some step be taken in the direction aimed at. An attempt was made on one or two occasions to introduce Bills, but these savoured more of a political move than of anything else. These Bills were ill-considered and would have defeated their own objects. Consequently, no definite action was taken until two years ago when the Government, yielding to the pressure of public clamour,

appointed a commission or intimated that they would appoint a commission. Immediately following that session there was a change in the Government. However, the administration on entering office implemented the promise of the late Government and a commission was apointed last January at the sitting of the House, to thoroughly investigate the question and to submit a report for consideration. This commission has been actively engaged since that time and I saw some of its members before I left. Their work so far has been confined to the compilation of efforts which have been attempted in other countries; they have made a digest of all existing legislation in the different countries of the world, bringing the matter up-to-date. For there has been no publication along these lines since 1926, when a Committee of the Labour Bureau of the League of Nations published two volumes dealing with the matter of legislation in extenso.

Now, in analyzing the report submitted by this Labour Bureau, it was found that since then amendments have been introduced by practically all of the countries concerned. These amendments showed two outstanding features which must be considered in connection with the principle of health insurance. The majority of the countries in introducing their Acts emphasized prominently the idea of the benefits to be paid for sickness. In going over the amendments since 1926 in the various legislatures, we find that these amendments are now taking an entirely different angle. In the first place, they are all adopting the principle of compulsion. In applying the Acts in the different countries they have found that by following the voluntary principle they were experiencing great difficulties. In the first place, they had to accumulate a reserve fund and to depend upon voluntary contributions for this purpose. From that reserve fund were paid sick benefits, and if it had not been that the states concerned came to the aid of the committee by large subsidies, in many cases the whole thing would have been a failure. The result is that one after another of these countries have dropped the voluntary method and are adopting the principle of compulsory health state insurance.

The second point that is noticeable in these amendments is that the countries concerned are getting away from the idea of benefits for sickness or compensation for lost services on account of sickness, and are spending more and more money and devoting more and more time to the idea of prevention and conservation. They have gone so far as to permit the committees in charge to use all their funds for these purposes provided they do not interfere with the reserve sufficient to maintain their financial position. One country after another has adopted this. In Great Britain they had passed an amendment already, in 1924, before this first report, permitting the use of the funds for the preservation and conservation of health, for medication, for hospitalization, and for the propaganda of hygienic teaching among the masses of the people. This principle is being carried out now in all of the countries. In France they had a national plan, a voluntary one, and have stuck to it consistently. After the war, when Alsace and Lorraine were incorporated in the Republic they continued the plan as carried on there previous to the war. This was the German plan, and they have watched it very closely for the past ten years. Now they have decided to drop the voluntary idea entirely and to implement it, as soon as funds permit, by a compulsory plan throughout the French Republic, and in a few years they will extend this to their colonies. In Switzerland the idea was accepted of compulsory health insurance and a government was returned to power on that issue. They implemented their promises by passing legislation and then referred it to the public in the form of a referendum for confirmation. Curiously enough, the public turned it down and the federal Government had to implement their policy by means of expediency, in allowing the different Cantons to introduce compulsory legislation so far as it concerns the territory within their respective bounds.

The Netherlands have had a voluntary health insurance scheme for years. This year, 1929, just lately, they have passed an Act—I received a copy and had it translated—adopting practically in toto the compulsory plan.

Now, as we follow out these trends we find that the idea that is being brought forward is prevention of disease. We had something this morning from Dr. Amyot with respect to provincial Governments being asked to provide sanitoria or other institutions for drug addicts. All provincial Governments are very chary at the present time in going ahead with further expenditure. In recent years the charge for sickness has become such an enormous amount, chargeable to the consolidated revenues, that it is seriously hampering the development of the provinces along these lines. Far too much money is being spent as capital expenditure, building elaborate monuments to architects in the form of hospitals. The great advances in medical science are demanding more and more expenditure in carrying out plans for the proper treatment of the patients, and, taking it all together, it has become, especially in British Columbia, as I have said, a very serious charge, so much so that at the last session of our legislature the Minister of Finance spoke at some length on the question, suggesting that some means would have to be taken to curtail this unnecessary expenditure. He considered it unnecessary, and in the last analysis it is. It is an expenditure which is getting beyond bounds, but there is no reason why the objects of that expenditure should not be regulated.

In our hospitals we have far too many liabilities; we have patients remaining too long, with a consequent piling up of charges. Now, we hear a great deal from the public about hospital charges and doctors' fees. Last week, in conversation, a well known doctor, who is thoroughly conversant with the subject, pointed out to me that in the last twenty years hospital expenses had increased enormously: charges had increased 60 per cent, while in the same time the cost of administration had gone up some 160 per cent. It is in an effort to control this tendency that health insurance is being taken up by the public. They have only a vague notion of it, but they see an object in view and are willing to try any means that will bring about a condition which will enable them to enjoy all the advantages of modern science, and at a lower cost. What has occurred to them is that the matter should be handled along business lines: There should be co-operation: some effort should be made at standardization: and business methods should be introduced, to the end that all citizens might enjoy the benefits to be derived from such a system, at a cost more in keeping with people's means.

In considering any question affecting the community as a whole, the matter of taxation is of course paramount. If we can get the cost distributed over a wide area we shall be able to accomplish something without forcing a large majority of the people to accept charity. At the same time, it would enable us to go into a hospital, as our children go to school, knowing that we have an interest in the institution, that we are fully supporting it, and that we are not merely accepting charity.

The people are looking for leadership in this. They are imbued now with certain ideas which were not in their minds before the war. During the war we had an opportunity to take a census of the conditions of the people as a whole, and the same thing will probably not occur again in our lives. But there was disclosed at that time the fact that there was something "rotten in Denmark" so far as the physical condition of our people was concerned. The health authorities took advantage of the information then acquired: governments backed them up, and an intensive campaign has been carried on ever since to bring home to the people the fact that the remedy lies in their own hands,—first, in cleaning house, and secondly in following out the advice given them by practition-

ers. It is imperative that we begin with the child. Why? A French writer once made this memorable statement: "If you want something that will last a hundred years, plant a tree; if you want something that will last a thousand years, plant an idea in the mind of a child." That is the basis on which the work is being carried on by all boards of health. We shall have to continue along that line, and if health insurance is adopted that must be the basic factor in the application of legislation—prevention. Other considerations will fit themselves into the scheme and bring about a realization of the present dream. The medical profession should now declare itself on this question. There is no use our continuing to think that we as a profession are sacrosanct, that we are simply to dictate and not to be questioned. The people are intelligent. All this intensive work of the various health departments is producing its effect; the people are working out the problem; they are asking questions and they will demand an answer.

If this legislation becomes effective—and I firmly believe it will—the medical profession should place its services at the disposal of the governments; it should act in an advisory capacity and should be recognized in any scheme that may be put forward.

The scheme we have inaugurated in British Columbia embraces service in all departments of the hospital: in other words, a medical man can give a prescription to his patient and send him to the hospital for X-Ray, or a laboratory examination, with free nursing service. The scheme contemplates public health teaching, beginning with pre-natal work, following the child all through school, and all included in the tax. Maternity benefits also should be included in the tax.

On working it out we found the cost to be very small compared with what is entailed to-day, especially for a young man starting out in life, getting married and expecting one, two or three children in the first few years. At present hospital and medical charges he cannot contemplate his future with peace of mind, and he does not attempt to obtain adequate service. Under such a scheme as this, however, he knows that his wife will be cared for, himself protected by periodic examination, and everything disclosed by modern research placed at his service; and he would have the satisfaction that would come from the knowledge that he was paying for it. That was our basic idea.

As to developments, I am of course not in a position to forecast anything. The royal commission is sitting, and what its report will be I do not know. What action the legislative body will take I cannot suggest. But so far as British Columbia is concerned, public opinion is so decided that the government is bound to be interested. Any man who has had experience in public life knows that when a government realizes that there is a majority, and a large majority, behind any idea it will give effect to that idea by means of legislation. And that is going to be the outcome in this regard.

If they do enunciate that policy, then the medical profession should be ready to step in, when that bill is framed, and give their advice, and suggest what attitude the profession as a whole will take, bargaining—if we must use that word—for proper representation and as to what the remuneration shall be.

It is not state medicine that we want; nor are we trying to make a glorified Civil Service of the medical profession. But there is a position we must assume, and that is, recognition of our profession on a professional basis and on a reasonable basis in regard to fees.

In British Columbia there has grown up a body of opinion which has made itself manifest; it has become articulate. Once a year we have a meeting of the representatives of all the municipalities of British Columbia. It is known as the Union of Municipalities, and this year it passed unanimously a resolution requesting the government to begin at once to give effect to health insurance. The

commission which is sitting at the moment, in order to ascertain precisely the feeling prevalent among the trades, manufacturing concerns and corporations, sent out a questionnaire, and within a month they had 192 answers. Of those 192, 100 came out unqualifiedly for compulsory health insurance; the others, while not committing themselves, furnished the data we wanted. But there were only 9 who opposed, that 9 representing but 4,500 employees. Of the 100 who suggested insurance—I should not have said they were all for compulsion—72 wished to have it made compulsory; and these 72 represented 35,000 employees. All the larger companies that were canvassed had pay-rolls in excess of $75,000; and such a clearcut declaration from them will no doubt have considerable influence on governmental action.

But the crucial point will be, so far as the profession is concerned, a declaration of policy on the part of the government. If the government say they are going to adopt the system, this is the time to approach them. In British Columbia we are already carrying it out in large measure.

Let me instance what occurred in the province at the time the Workmen's Compensation Act was put through. I happened to be in the Government at the time, and though it was not in my department I looked through the draft bill carefully when it came before us to see what recognition there was of the profession. I saw no mention at all of a medical man. I thereupon asked that the matter be held up, and not introduced into the house pending a meeting of the medical association. I pointed out to them what the situation was from the point of view of the profession but none of them paid the slightest attention to it. They formed a committee, one of whose members came to me the next day with the impatient question—"What in heaven's name is this health insurance?" I said I was not sure that I could answer the question in five minutes. "Some of the brainiest men", I told him, "are working at it and endeavouring to find a solution. There is a good deal of material in the library, but as the committee meeting is to-morrow night I am afraid you will not be able to dig up much. The best thing you can do is to go to the government and ask them what can be done". And they did, with the result that finally there were incorporated in the act certain clauses dealing with the medical fee. It has worked out so well that the profession, before I left, asked me to represent them as being entirely in favour of it. When the matter first came before them my name was anathema; now their attitude is very different. Dr. MacDermot of Vancouver, was here at the first meeting of the services and he has given a great deal of attention to the subject. I am sorry he could not come to-day, but he is willing to co-operate with the Government.

The medical profession is willing to co-operate on the basis of having its fees guaranteed to the extent provided for under the Workmen's Compensation Act—that is to say, 65 per cent of our standard fees. That is the position of the profession to-day.

There are some large corporations that maintain a practical system of health insurance themselves, the employees, and sometimes the corporations also, contributing to its upkeep. In some cases this insurance extends to the families as well. At any rate, the theory is put into practice. It will be seen at once, however, that there is a discrimination against those employees who do not belong to such a scheme; one company contributes while another does not. If, on the other hand, the system were standardized, all classes would benefit. I have in mind two companies, both in the same line of business, employing hundreds of men and women, both having internal insurance: one firm is contributing $18,000 a year towards the fund, while the other company, equally able to contribute, provides the services of a book-keeper to look after the accounts of the men. That is discrimination in the trade, which would not prevail under a standardized policy.

Standardization will bring about the unification of all services. It will make for the peace of mind of the man with a family, for he will know that sickness will not necessitate the mortgaging of his whole future. It will put that fear out of his mind. He will get the benefit of every advance in medical science; he will have the services of men who have fitted themselves thoroughly for their profession; and as a free and independent citizen he will take advantage of a situation which he himself is helping to make possible. He will feel that he is not the recipient of mere charity, but that he is getting something for which he is paying.

The CHAIRMAN: Dr. Young has brought us a very definite message which we particularly appreciate inasmuch as British Columbia in so far advanced in the study of this question. It is being taken up, not only by the medical profession of that province, but by employers of labour independent altogether of the Government Commission. The results of their study, I understand, is ready now and will be made available to that Commission. The reason Dr. MacDermott is not here to present his views on this question to this conference is because he is appearing before that commission on this very date.

I will now call upon Dr. M. R. Bow of Edmonton to continue the discussion.

Dr. M. R. Bow (Edmonton): Dr. Young has covered the whole field very well in so far as health insurance legislation in other countries is concerned, and I think it will possibly be of more interest for me to touch briefly on some of the more salient features of the preventive work being carried on by the Department of Public Health of the province of Alberta.

As you may know, at the 1929 session of the Alberta Legislature, a report was tabled on Systems of State Medicine. This report, which was requested at the previous session of the House, has now been printed and is available for those who are interested in this question. It is simply a review of the systems of health insurance in effect in different countries such as Germany, Great Britain, France, Australia. It also touches briefly on the principles applied in connection with health conservation and the prevention of disease in different parts of Canada. In dealing with this question at this time, I am merely going to touch upon some of the more outstanding features of the work as it is carried on in the province of Alberta by the Department of Public Health.

The following are the most important of the Acts administered by the department: The Public Health Act and the regulations administered thereunder; the Municipal Hospitals Act, the Hospitals Act, Private Hospitals Act, the Vital Statistics Act, the Marriage Act, the Venereal Diseases Act, the Mental Diseases Act, the Mental Defectives Act.

MUNICIPAL HOSPITALS

The Government of the province has encouraged an extensive development of municipal hospitals. There are now twenty such hospitals in operation, providing accommodation for 392 patients and organization is under consideration in six additional districts. These hospitals serve almost half of the rural population of the province and are modern in construction and equipment. A municipal hospital district is established by the minister on petition of the municipal councils or ten per cent of the rate payers residing in the territory included in the hospital district.

A scheme is prepared and submitted to the vote of the people, a two-thirds majority being required for its approval. This gives a general idea of what the people may expect in the way of hospital service. Funds are raised by issue of debentures which are retired over a term of years. All assessable land in a hospital district contributes towards its support, the average tax per acre in a hospital district being three cents. All hospital rate payers or supporters,

including their families, are entitled to hospital service at the rate of $1 per day. By "supporters" is meant certain individuals in the community who are employed on farms or in the towns who may not be tax-payers, but by payment of a certain stipulated sum, which in most cases is $6, may become hospital supporters and entitled to the privileges of the hospital. The Municipal Hospital Board composed of representatives of the districts included in the Municipal Hospital District, is elected at the annual municipal elections and this board is responsible for the operation of the hospital under the provisions of the Municipal Hospital Act, the department acting in an advisory capacity. These hospitals have proven a great boon to the people, providing hospital service for many sections of the province which would otherwise be denied it. The danger which must be guarded against and which actually develops in connection with the work carried on in certain hospitals is the tendency to attempt major surgical work which could be better done in large hospitals in centres of population. On the whole, however, we have found that these hospitals, are now largely confining their efforts to the real work for which they were built, that is, for providing maternity service, emergency service, and medical care to those who live within the bounds of the Hospital District. These hospitals have been very successful financially—practically all reporting cash surpluses at the end of 1927.

The Municipal Hospital System is in itself a form of health insurance. Those who reside in the district and are rate-payers, contribute whatever their tax may be and are entitled to hospital service, as are also the members of their families, should they require it.

All approved hospitals in the province, including the municipal hospitals, are paid a grant of fifty cents per day. The amount paid by the Government to the hospitals of the province in the way of grants exceeded $400,000 in 1928.

The Provincial Sanitorim, provides accommodation for 210 patients and is operated under the direction of the department. Municipalities are held responsible for the maintenance of their residents who are unable to pay for sanatorium treatment. The average per diem cost is about $2.75, but the charge made for the maintenance of any patient who is a charge upon the municipality is $1.50 a day. The balance of the cost is made up by the Government. Travelling diagnostic service is carried on from the sanatorium, the diagnostician travelling by car through the different sections of the province in the conduct of this work. The medical staff of the sanatorium provides the medical service for the chest clinics in Edmonton and Calgary.

Another type of hospital work which is of interest in connection with the question of health and the state is that of the Provincial Special Hospital for the after-treatment of poliomyelitis cases, which was opened in January, 1927. This hospital provides special facilities for the after-treatment of sixty cases. It was opened to meet the need for this special service following the outbreak of poliomyelitis in 1927. The charge for maintenance is $1.75 per day, including hospital and medical service. A teacher is employed to give bedside instruction to the children and dental service is also provided. The cost of maintenance is $2.75 per day, the Government assuming $1 of this case. Patients are admitted irrespective of their ability to pay for treatment. The medical officer in charge of the hospital is an orthopædic surgeon.

As many of you know, the after-care of these patients constitutes a very serious problem particularly in a province such as ours where sixty per cent of the population is rural and far removed, in many cases, from hospital and medical care, and where the mothers in their homes are, in so many cases, entirely unable to carry out any of the forms of treatment which may be advised. This institution has met a real need, and is, I believe, the first institution in Canada, to be built and equipped for this special work.

MEDICAL SERVICES IN OUTLYING DISTRICTS OF THE PROVINCE

Eleven physicians are under contract with the department to provide medical service in unorganized districts to indigent persons and to perform the duties of health officers in these districts. A contract is entered into between the physician and the department by which provision is made for the treatment of patients, the handling of outbreaks of contagious diseases and for emergencies.

For major surgical cases which the physician may be called to attend, he is paid an additional amount over and above the contract, on the basis of the Workmen's Compensation Board schedule of fees. We have, in addition, three physicians stationed in outlying districts remote from medical and hospital service. The salaries of the latter physicians are paid by the Government. In the districts in which these three physicians are located, settlement is rapidly taking place, but the great majority of the people are still carrying on under pioneer conditions.

PUBLIC HEALTH NURSES

These are graduate nurses with special training or experience in public health work and may be classed in two groups:—

(1) *District Nurses.*—These are stationed in frontier communities where there are no medical or hospital facilities of any kind available. These nurses are carefully selected and required to have had special obstetrical training. They provide a special service in first aid, midwifrey, bedside nursing, child hygiene and the many other services expected of them in a pioneer community. There are at the present time six of these district nurses, who with one exception, are located in the northern part of the province.

(2) *Public Health Nurses.*—Public health nurses are in charge of child welfare stations in each of the cities of Calgary, Edmonton and Medicine Hat and by arrangement with three rural municipalities, public health nurses are stationed in these municipalities. One half of the salaries of the latter are paid by the municipalities and one half by the province. One public health nurse is engaged as lecturer and demonstrator in home nursing and first aid. She visits small urban and rural communities at the request of local organizations. There is a widespread demand for this service.

CLINICS

A travelling child welfare clinic is conducted, districts being visited at the request of local organizations. These clinics deal almost entirely with the child of pre-school age, the children being weighed, measured, inspected and mothers advised with reference to diet and the correction of defects. The co-operation of local physicians is invited in the conduct of this work.

TRAVELLING CLINIC

The travelling clinic is an outstanding feature of health work of Alberta which has been under discussion at different times and to which I shall refer briefly.

This clinic was established to meet the great need for medical and dental service for children, particularly those living in districts remote from medical and hospital service. Districts are visited at the request of local organizations, generally local school boards, local branches of the Women's Institutes, etc. The staff of the clinic consists of one surgeon, one physician who assists in physical examinations and acts as anaesthetist, two dentists and four nurses. Districts requesting the service of the clinic are first visited by public health

nurses who make a survey of the schools in the district. Eleven thousand children were inspected by these nurses in 1928, 5,868 were examined by the medical staff of the clinic, and 1,647 tonsil and adenoid operations were performed, 108 other minor operations were performed, 5,535 children were given dental examinations. Dental treatments numbered 1,306, fillings 286 and extractions 2,678. The parents are present during the examination of the children and this offers an exceptional opportunity to impart health instruction of which full advantage is taken. A charge of $15.00 is made for tonsil and adenoid operation and a moderate charge for other minor operations and dental work in the care of those who are able to pay for the service. No charge is made where financial circumstances are such that they are unable to pay for service. In 1928 the clinic worked in three units, two examining and one surgical, but in 1929 only one unit, a combined examining and surgical unit was maintained in the field. The demand for the services of the travelling clinic has been such that it has only been possible to arrange an itinerary covering part of the districts requesting the service during the five months the clinic is in the field. Physicians practicing in proximity to districts visited are notified in advance of the visit of the clinic and invited to co-operate in its work. Many of the children examined at the clinic are referred to family physicians for after-treatment. With one examining and surgical clinic in the field, three days are spent at each centre. The most important feature of the work of the travelling clinic is the educational one. Health conservation and disease prevention is stressed by the staff of the clinic as well as by the public health nurses who make the preliminary survey.

DISTRICT HEALTH UNITS

It has long been recognized by public health authorities that the full-time service of a well qualified public health staff is essential in the conduct of an efficient public health service. There has been little progress in rural as compared with urban health work, largely because we have not had the necessary health machinery operating in rural districts. Sixty per cent of the population of Alberta is rural. At the last session of the Alberta legislature an amendment to the Public Health Act was passed by which the Minister of Health is given authority to establish district health units when requests are received from a sufficient number of municipal councils to warrant the establishment of such units. At least six rural municipalities, with the included towns and villages would be required to provide an area of sufficient size. The minimum staff of such district health units would consist of a medical health officer specially qualified in public health work, one or more well qualified public health nurses, a sanitary inspector, and an office assistant or secretary technician. At the office of the health unit a district laboratory would be established, providing public health laboratory service for the territory served, as well as adjoining districts. The annual budget of a district health unit would be from twelve to fourteen thousand dollars. The district health unit would perform the older public health functions, such as the control of epidemic disease, inspection of food and water supplies, the registration of vital statistics and the newer functions such as the discovery and control of tubercuIosis and venereal disease, the medical inspection of pre-chool and school children, the conducting of clinics and educational activities in pre-natal and post-natal maternity work and general health education among children and adults. In two phases of its work, namely child and maternity hygiene, such district health units have open to them large opportunities. Most of the work needed in Alberta as elsewhere is educational and the district health unit is the logical centre for the work.

CONTRACT DOCTORS

Municipal Doctors.—As in Saskatchewan, there has been considerable use of contract medical practice in Alberta, chiefly in connection with mines and railroads. In addition, several municipalities pay doctors whole or part salary for their services.

Private Contract Doctors.—Nearly all the medical and hospital work in mining towns, lumber camps and much of it for railroad employees, is carried on by contract medical practice. Some twenty doctors devote whole or part time to such practice, caring for some 2,800 men and their dependents, or a total of approximately 25,000 persons. In addition to the contracts for medical service, contracts for hospitalization have been in effect. Drumheller Municipal Hospital has agreements for hospitalization with some 1,350 employees of twelve mines in that area. The cost to the employee is $1 per month for which the hospital provides accommodation for a man and members of his family when ill. The only additional charges are for operating room—$2 in minor operations and $5 in major, and an extra charge for X-ray service.

MENTAL HYGIENE CLINICS

Mental Hygiene Clinics have recently been established in Edmonton and Calgary. A psychiatrist, who is medical superintendent of the Provincial Mental Institute at Oliver, is in charge of this work. These clinics have been established in an effort to apply the principle of prevention to the mental field, a field which has been almost entirely neglected in the past.

PUBLIC HEALTH EDUCATION

A new division of public health education has been established in order to co-ordinate the public health educational work of the different branches of the department and to meet the rapidly growing demand for lectures, films, exhibits and literature dealing with various phases of public health.

Dr. Young has touched on the health insurance scheme which is likely to be brought forward in the province of British Columbia. I may say that the development which has taken place in British Columbia and in the other provinces of Canada has aroused a great deal of interest and is being watched very carefully in the province of Alberta. There is no doubt a change is in prospect in all our provinces. Just what form it is going to take, time alone will tell. I think the important thing is for the medical professions in every province of Canada to be informed and prepared to co-operate intelligently in the development of whatever scheme will promote the most satisfactory type of medical service in the several provinces.

The CHAIRMAN: We are now to hear from Dr. Middleton.

Dr. F. C. MIDDLETON (Regina): There appears to be at the present time, in the Western provinces more particularly, a desire on the part of various lay organizations for some change in the system of medical practice, particularly in the matter of paying for medical services. This wave of dissatisfaction with existing methods as related to the medical care of the sick and with the cost of same will no doubt in due course reach from coast to coast and become a national issue.

Curiously enough, this matter is being discussed not alone by organized labour, that is by wage-earners, but also by the great body of agriculturists of the prairie Provinces. If, therefore, it is considered that some form of state or health insurance may help solve these problems, this new feature of making provision for the farming classes must also be included. Usually, in speaking

of health insurance, we think only of a plan or scheme whereby certain wage-earners, earning below a stated salary, may participate and farmers are not considered in this group.

At the first conference on Medical Services in Canada, held in 1924, Dr. J. H. MacDermot of Vancouver gave a very fine address on health insurance, as this problem has been given special study by the profession in British Columbia. As evidence of the value of this study and preparedness, he points out how the medical profession has been able to co-operate with the labour committee in having a fairly satisfactory Workmen's Compensation Act passed. As the problems of each province are somewhat different, it behooves the medical profession of each to make a similar study and so be prepared to guide in matters appertaining to the care of the sick. In Saskatchewan, for instance, the United Farmers are asking for a free Travelling Consultative Clinic. Whether or not details could be worked out to provide this has not yet been decided, but it would appear that at this stage the medical profession would be in a position to discuss the matter freely and frankly with the United Farmers, and could guide and direct them to some feasible solution agreeable to both. It is an opportunity for leadership by the profession in a matter vitally affecting ourselves.

The special subject allotted to me is public health as related to state or health insurance, and I propose not to confine my remarks to straight health insurance as we usually think of it, but with your permission wish to touch on some of the various ramifications of health insurance as they affect the practice of medicine. The latter may not all be state supported directly, but inasmuch as they are financed by taxation, in my opinion they may justly be considered as forms of health insurance and would appear to be significant forerunners of this important problem. Our present day literature contains a good deal about state or health insurance, mainly as it exists in England and Wales and known as the "panel" system. Opinions vary as to the success of this system, but it is generally conceded that from the viewpoint of the doctor, it is working with a fair degree of satisfaction and when it is considered that about one-third of the population is on the panel and to this number is assured continuous, steady medical attention, the amount of sickness and suffering cannot help but be greatly minimized. The natural tendency would be to call the doctor or consult him much earlier under the panel system than otherwise, thus giving the attending physician much better opportunity to satisfactorily deal with the case and so benefiting the patient to the extent of lessening his period of illness and time off work. With less sickness and loss of time, there is less poverty with all its accompanying tendencies to more sickness. The need for institutional care should also be reduced, due to early diagnosis and early treatment and should prevent many incurable conditions. The educational feature is important also, in that the people get to appreciate the importance of early recognition of disease. This should especially apply to such diseases as, cancer, tuberculosis, heart disease and pneumonia, four diseases which are found at the head of the list of diseases causing death.

Living conditions, however, in a country like Canada, with a population of $2\frac{1}{2}$ per square mile, are quite different from those in the Old Country with a population of 500 per square mile, so that the methods of dealing with similar health problems here require different solutions. Attempts are being made in various rural parts of the Dominion to meet the situation by providing medical and hospital service for those rural residents.

MUNICIPAL DOCTORS

The population of Saskatchewan for instance is over 75 per cent rural, and it is becoming more and more difficult to retain medical men in the smaller

rural centres, as oftentimes the population does not warrant a doctor residing there. To give these people the assurance of having a medical man reside in their midst, legislation has been passed whereby a rural municipality may give a grant up to $1,500 a year to a physician for this purpose, or the municipality may engage the full time services of a doctor at a salary not to exceed $5,000 a year. At the present time, ten municipalities give an annual grant to a physician varying from $900 up to $1,500 a year to have him reside in the municipality. The conditions under which the grants are given vary greatly: All require that the doctor reside within the municipality and that he act as medical health officer. Most agree to giving free medical care to all indigents within the municipality and some make a reduced mileage charge, as distance from a doctor adds greatly to the cost of medical service.

Seventeen rural municipalities engage the full-time services of a doctor, the salary varying from $3,000 to $5,000 a year. The agreements here also vary a great deal. A fairly typical agreement would be: That the doctor act as medical health officer; that free medical attention be given all resident ratepayers and their families, also to those indigents who are not ratepayers; that no charge be made for maternity cases; that vaccination against smallpox and immunization against diphtheria be carried on among school and pre-school children; that prenatal consultations be given; and that school children be medically examined once a year. In some instances, the doctor is allowed to charge one or two dollars for the initial visit. The preventive work accomplished under these conditions can be readily seen.

In addition to this, a nurse may be engaged by a municipality to ensure the services of a trained nurse when such are needed. As an illustration of the result being obtained where this scheme is in operation, I might quote the statistics in Rural Municipality of Hillsburgh No. 289. A municipal doctor has been engaged there for a number of years and in addition the municipality out of its taxes pays for the services of a nurse for any of its ratepayers for a period of 15 days in any one year, when in the opinion of the doctor a nurse is required. A nurse is supplied for all maternity cases. The nursing service in 1928 cost $2,053. This municipality has a population of about 1,350. Taking a period of six years, 1923 to 1928 inclusive, there were in that municipality 185 births with no maternal deaths. There were 25 deaths from all causes in the six years, representing an average death rate of 3·3 per 1,000 population. Of these 25 deaths, there was 1 drowning; 1 fractured skull; 1 intussusception; 1 infant found dead on railway track; 1 suicide; 1 accidental scalding; one aged 69, two aged 70, one 74, one 78 and one 80, and 9 under 1 year of age. The first 12 deaths might be considered as uncontrollable deaths. The infant mortality rate was 48·7 per 1,000 L.B. There was not one death from a communicable disease in the six years.

A very noticeable feature about the municipal doctor scheme is that where it is adopted by one municipality, invariably an adjacent municipality also adopts it, and I do not know of any municipality giving up this scheme once it has been tried out. The success or failure of course depends largely on the doctor employed. Financially, the doctor is much better off because he has no bad debts and from a public health standpoint this system next approaches the Full-time Health Unit.

IMMUNIZATION

In Saskatchewan, during the past few years we have been conducting a steady campaign for vaccination against smallpox and for protection against diphtheria with toxoid. We have had splendid response and in practically all the municipalities, financial arrangements with the local doctors for doing this

work have been made by the various councils. This is now being considered a community responsibility, to be paid for through taxation. Where there is a municipal doctor, immunization work has been carried out extensively.

FULL TIME HEALTH UNITS

Until quite recently in Canada only cities alone had the advantages of a full-time medical health officer, with a staff of full-time sanitary officers and public health nurses. In several of the provinces, now, however, a public health service similar to that found in a city but applicable to rural districts, has been extended to the rural areas the size of which area corresponds to an ordinary county. As this system is considered not only a local protection against preventable disease but also a community protection, the cost is met partly by local taxation and partly by provincial aid, and it is generally conceded that a portion of the cost should be borne by the federal government. From the public health viewpoint this would appear to be the most effective system which can be adopted and is one of the greatest single mediums for the advancement of public health to-day. As in all public health work the co-operation of the medical profession is of course necessary.

HOSPITALS

State aid to General hospitals at least to the extent of one-sixth of the operating cost is universally paid. In addition to this, provision is made by legislation whereby in Union hospital districts the ratepayers may tax themselves for the purpose of furnishing free hospital treatment for any ratepayer in the district. That is, the hospital fees are paid for, through taxation, in a manner very similar to that in which a school is supported. There are many different arrangements made by such Union hospital boards. In some cases the whole hospital fee is paid by the municipality; in others, the patient pays a very nominal hospital charge, possibly one dollar per day, and the taxation takes care of the balance of the cost. In some the number of days' treatment for each ratepayer during a year, at the expense of the municipality, is limited. In others only the hospital fees for maternity cases are paid by the municipality, and in some the hospital fees up to a certain rate per day are paid by the municipality if the patient wishes to go to any hospital other than their own local hospital, that is, the ratepayer may have his own choice of hospitals.

In all cases where the Union hospitals are established, even though free hospitalization is not provided, all deficits are made up by the co-operating municipalities, so that these hospitals are always in a good financial position and their support is no longer haphazard and dependent on bazaars, drives, fees from entertainments, etc., as formerly. Bad debts are practically eliminated.

In one Union hospital at Rosetown where treatment through taxation is adopted, the following arrangements are made: Two municipalities pay for hospital fees of all resident ratepayers, their dependents, hired help and school teachers if resident for thirty days. Two others pay the same, only that school teachers are omitted. One municipality not in the Union hospital scheme pays for the hospital treatment of its resident ratepayers and another municipality not in the scheme pays $2 towards the hospital expense of its ratepayers. One village pays for twelve days in any one year.

It might well be said that these small Union hospitals have been the means of retaining a medical service in a district where otherwise none would be available. Further, the number of hospital beds have been largely increased as a result of the Union Hospital Scheme, there being now in Saskatchewan 3·9 hospital beds per 1,000 population. The people are also recognizing that

when sick the proper place is in the ward of a well-conducted hospital. In 1928, 7 per cent of our population had hospital treatment, and this has no doubt reflected favourably on our death rate, which was 7·2 per 1,000 population. One out of every 3·9 of the children born in Saskatchewan was, last year, born in a government-aided hospital. This also has a very direct bearing on the maternal and infant mortality as the people are now educated to hospitalization. Our maternal death rate has reduced from 7·7 per 1,000 L.B. in 1926 to 5·8 in 1928, and the infant mortality reduced from 81·1 per 1,000 L.B. in 1926 to 64·4 in 1928.

SANATORIA TREATMENT

On the first of January, 1929, the new Tuberculosis Sanatoria and Hospitals Act was passed, making the following provision: Every person suffering from tuberculosis or who on the certificate of a duly qualified medical practitioner is suspected of so suffering, shall be entitled to receive care and treatment at the expense of the Anti-Tuberculosis League, providing that person is a resident of Saskatchewan and has been a resident thereof for a period of at least six months prior to his application for admission to a sanatorium or hospital.

In the province of Saskatchewan the sanatoria are built and equipped by the Government and then handed over to the Anti-Tuberculosis League to be operated. The new Act provides that the cost of operation shall be borne as follows: The Government pays one dollar per patient per day to the league (This is one-third of the cost) and the balance is borne by the municipalities, urban and rural, proportionately on the basis of their total equalized assessments. The burden is therefore spread equally over the whole province and the total cost of treatment is provided for by taxation. I know of no other place where such arrangements as these are made and under these conditions tuberculosis should now be almost entirely under control. Further, salaried medical men, employed by the league, visit several of the cities weekly, in order that any practising physician may refer a suspected case of T.B. to the travelling diagnostician, or the diagnostician will upon request arrange to visit the smaller centres for consultation.

In addition to this service, the league will pay to any physican a fee of $5 for examination and report of a contact of a known tuberculosis case.

These measures should very soon lower our present fairly low death rate of 44·4 per 100,000 from tuberculosis.

MENTAL HOSPITALS

Providing hospital facilities and medical care for those suffering from mental diseases, at the expense of the state, has long been a recognized arrangement and the time has now arrived when the more general use of psychiatric clinics, staffed by specialists in this line of work, must be considered. These psychiatrists are being employed by the Government and can be utilized in preventive as well as diagnostic work.

ISOLATION HOSPITALS

The more general use of isolation hospital facilities for almost all communicable disease, would undoubtedly minimize the spread of the disease and reduce the many complications following such diseases. The expense of such hospitalization might well be considered as a community one, that is, free to the patient.

VENEREAL DISEASE DISPENSARIES

Treatment of venereal disease is expensive and prolonged. A large percentage of those contracting V.D. has very little money and were it not for

the government dispensaries staffed by salaried medical men, many cases would of necessity neglect treatment, continue to spread the infection, and eventually fill our general and mental hospitals.

The Department of Indian Affairs already provides for part time medical service for the Indians and I understand the matter of full-time service is being considered. With full-time service, there will be a wonderful opportunity for preventive work.

Veteran soldiers under certain conditions are entitled to medical treatment through the Department of Pensions and National Health.

Railroads and industrial organizations are all interested in keeping their employees well and find that by contract medical practice much loss of time through sickness among employees is eliminated and the employee is able to do more and to do it better as a result of his good health, hence better service and greater production.

Insurance companies also find that by having their policyholders periodically examined, their death claims are fewer, hence they engage doctors for this work. Periodical medical examination of the apparently well should be encouraged.

MEDICAL INSPECTION IN SCHOOLS

In New Brunswick medical inspection in schools is undertaken by the medical staff attached to the provincial Department of Health and in other provinces this is done by arrangement with the local part-time medical health officer, or by a school physician under the direction of the Trustee Board.

MATERNITY GRANT

In one province at least recognition as to the need for financial assistance at confinement has been given by the Government and this grant last year enabled over 500 (521) mothers to have medical attention at this period. The amount of the grant is $25 and undoubtedly had a favourable effect on maternal and infant mortality.

The distribution by the state of smallpox vaccine; diphtheria antitoxin and other biological products, has had a far-reaching effect in helping to control communicable disease, in addition to lowering the mortality and morbidity from these diseases.

Free laboratory service provided by governments, as aids to diagnosis, has also been a factor in the control of disease.

The Workman's Compensation Acts have resulted in more safety appliances being designed to prevent accidents, and the prompt care given to the injured aids in a more speedy recovery. These Acts have also resulted in preventing diseases due to certain occupations.

I have attempted to point out the numerous forms which health insurance in its broadest sense may take, the conditions in a district largely determining what system shall be adopted. Each system has either a direct or indirect bearing on public health and in many instances the curative and preventive phases have no very sharp and distinct demarcation but rather dovetail one into the other. Any form of health insurance should be of such a nature that it will not only help to regain health but also to maintain it.

We cannot deny the fact that at the present time there is a growing community responsibility in matters relating to sickness and health requiring constructive leadership, and for this leadership the medical profession should be ready and prepared. Further, the public must be made to realize that our present-day knowledge of disease, its diagnosis, treatment and method of prevention is far in advance of the application of that knowledge and that if this

knowledge is more actively applied, sickness and ill health could be reduced by one-third. Would some suitable form of health insurance nationally adopted assist in attaining such an objective?

The CHAIRMAN: Dr. Warwick has been deputed by Dr. Melvin to take his place.

Dr. WM. WARWICK (Saint John, N.B.): I regret that I have been asked to speak for Dr. Melvin, for the obvious reason that I cannot cover the subject as comprehensively as he could. We have not the same problems, nor have we gone, in some respects, quite so far as they have gone in the west. However, in the few minutes I have I shall try to review what our province has done and is doing in the matter of health, and particularly from the standpoint of prevention.

As you know, ours is, with one exception, the smallest province in the Dominion, with a population of slightly over 400,000. And that population has not increased in recent years; if anything, it is diminishing slightly.

A little over ten years ago an entirely new health act was passed by the legislature, which act, in some respects, is rather drastic compared with the old law. The system, briefly, is something like this: there is a provincial Department of Health, with the whole province divided, first of all, into health districts. There are now four health districts, each one in charge of a full-time district medical health officer. Each district medical health officer has a certain number of counties under his supervision, and each of those counties has a board of health of its own. The representatives on that board of health are appointed by the municipal government—that is, the county government—and also by the cities and incorporated towns. The provincial Government has its representative on that board.

In every instance but one the medical health officer of the district is the chairman of the Board of Health in that district. Each of the boards has its own minor officials, but there are no local medical health officers—no part time health officers.

The local boards operate under provincial regulations and are responsible to the provincial Department of Health; and, of course, the provincial department, through the minister, is responsible to the Government.

The provincial Department of Health has altogether 14 full time medical officers; one chief medical health officer, who is also registrar-general of vital statistics: one director of laboratories: four full-time medical health officers; six full-time medical inspectors of schools; and two travelling diagnosticians. The salary of one of these diagnosticians is provided in large part through a fund from the insurance grant, which is derived from the Canadian Tuberculosis Association.

We have the usual services in our Department of Health: vital statistics, sanitation services, and laboratory work. We have full time medical inspection of schools covering the whole province, rural and urban; but there is no treatment, cases for remedial measures being referred to private physicians and the hospitals.

I may observe, in connection with the medical inspection of schools, that in the last ten years our officials have vaccinated in the schools practically one hundred thousand children, with the result that we have almost entirely eliminated smallpox as a problem in our province, although formerly it was a very troublesome affair. The only trouble we have now from smallpox is, once in a while an imported case.

We have also, of course, a nursing service; but it is still very small, and apparently it is a matter of some difficulty to enlarge it.

We maintain a considerable number of serum depots, where the department supplies the usual type of material. Then we have our venereal disease clinics—nine altogether in the province—under the direction of part time officers, who of course are paid directly by the department, just as in other provinces.

As regards tuberculosis, in addition to our chief diagnosticians we have two tuberculosis institutions in the province. The larger one has, or will have in a very few weeks, a capacity of 175 beds. That is a municipal institution for the city and county of Saint John, and it receives patients from other parts of the province, provided they pay the necessary difference in fees, or their municipality pays in the event of their being unable to do so themselves.

We have also, the provincial sanatorium, with 100 beds. It is maintained by the province, and patients who have not the means are paid for by the various municipalities.

We have practically no remedial clinics, apart from one or two tonsil and adenoid clenics which are organized largely through the Department of Health ; and those who are able to pay a certain amount are expected to do so. That service we have not found it possible to enlarge very much. In the venereal disease clinics, treatment is given in much the same way as in the other provinces. Public clinics have been established in the larger centres, but that service we have not been able to extend to the rural districts—at least, not in any large measure.

Of late—in the last thirteen months—we have been carrying on a very active campaign for the treatment of children in active immunization against diphtheria, and these clinics have been carried on under the direction of the Department of Health, or of the sub-district boards of health, by officials of the department and also with the assistance wherever possible of local physicians. This, we have found, has had a marked tendency to improve the relations between the practising physicians and the department. We feel that as a result of what we have been doing in these thirteen months we are coming to a better understanding with the profession, and are getting over many difficulties which we encountered at first.

In thirteen months we have completed the inoculation of very nearly twenty thousand children in the province, so that we feel that we are making a rather good start in that direction.

We have in the province, a few large hospitals, but most of them are very small. The smaller hospitals are mostly private or community affairs, while the larger ones are municipal or city institutions. Of course, they are administered differently. They receive no per diem allowance, except the tuberculosis institutions, which get from the provincial authority a per diem allowance of $1, irrespective of the length of stay of the patient in the hospital.

The other hospitals do not receive a per diem allowance; they are given a specified lump sum, which however is not very large.

I do not fancy there is very much I can add to the discussion, but I feel that as time goes on there will have to be a much closer relationship, and a closer co-operation, between the practising physician and the Department of Health, and this no doubt will work to the advantage of both.

Dr. P. A. Creelman (Charlottetown, P.E.I.): The work that has been done in Prince Edward Island in the way of public health has been done mainly by voluntary organizations. Leading in this work has been the Red Cross Society, assisted by the Canadian Tuberculosis Association, and until a year ago, there was only a part-time health officer. In January, 1929, the provincial Government appointed a physician, full time, as chief health officer and tuberculosis travelling diagnostician.

These voluntary organizations have done a great deal of work. I believe that the Red Cross Society, with four nurses on its staff, is equal to any nursing service to be found in any other province. That is one statement I can make unhesitatingly, and I think it is a matter for gratification on the part of Prince Edward Island.

When I was asked to speak here I really did not know what I should say. Health insurance is not a problem with us; public sentiment has not yet reached that stage. But judging from what has been taking place in the other provinces we can surmise just how long it will be before we will begin to consider it. Personally, I feel it is not going to be very long. In the meanwhile, and until that time comes, we must dispose of our difficulties in some other way.

The problem we have to discuss here this afternoon is the value of preventive medicine and its administration. During the past year I have been trying to study local public health problems, at the same time looking into what is being done in some of the other provinces, in order to utilize all good points applicable in building up our local organization. I may be a little critical in some of the remarks I make by reason of the fact that I have been observing others. There are three points which occur to me, the improvement of which, I feel sure would facilitate the administration of preventive medicine and public health work generally. First, I do not believe our medical schools are giving students the preventive view in medicine. Secondly, there is not proper co-operation between public health authorities and the practising physician, and thirdly, there is the question of educating the public.

As to the first point; preventive medicine has not been given in the universities that dignity which it deserves. As regards the acquiring by the student of a proper public health point of view, I believe it is impossible for him to get it completely within the wall of the university. That must be supplemented by field work. But when you consider how overburdened the curriculum is already, how are you going to help him? What is public health, after all? It is nothing more than the application of sound common sense. Our medical students are getting an adequate education; the problem is, applying that education in a preventive way. There is one solution, I believe, which would help in this way. If the students after they have had bacteriology and some lectures in hygiene, were able to do field work with a competent health officer for, say, three months during vacation, I am sure they would get a more valuable viewpoint of medicine from its preventive side. This would be very similar to the principle followed in the preliminary training given to health officers by the International Board of Health. This scheme could be greatly facilitated by the giving of scholarships of amounts from $100 to $300 to the undergraduate. Personally, I feel that these students could also be of great help to the health officers in the way of making sanitary surveys, etc., and at the same time, the student could be introduced to actual problems and thus obtain some practical knowledge.

The next point is the relationship between the practising physician and the public health authorities. Are the public health authorities trying to meet the physician as they should? Are we putting ourselves in the physician's shoes and viewing the Health Department as he does? I do not think so. There seems to be a tendency on the part of both health authorities and voluntary organizations to underestimate the ability of the practising physician to take care of the public health. This is what I have observed, not only in this country but in the United States also.

What are we going to do about it? I have faith in our physicians, and I think they can be relied upon to carry out public health measures. There is one satisfactory way of dealing with the practising physician, and that is for the provincial health officers to get out and meet the men in their own field. This is one respect in which the Canadian Tuberculosis Association has done

a great deal of work. Travelling diagnosticians have been able to meet the physicians in their own sphere. Some of them are carrying out a number of examinations in the clinics, and that is all to the good, but I do not believe that the examinations that are being made are as important as the contacts which are made with the doctors and with the patients.

Regarding the control of communicable diseases, public health authorities are far from dealing thoroughly with this matter. If the practising physician was as interested in the preventing of communicable disease as he in in curing them, they could be controlled much more effectively than they are now. It should be his duty to instruct the public in the proper methods of their control as well as the duty of the public health officers. If he has any difficulty in getting the public to comply with regulations, or if, for diagnostic purposes, a consultation is necessary, why, then call the chief health officer. But to effectively control communicable disease, he must know and put into effect, the regulations governing them.

I do not wish to be over critical of the public health authorities; possibly the physicians have not co-operated with them as they should. But let us look at the question from the physician's point of view. We invade his territory, and it looks as if we were trying to clip a little bit of his revenue here and there. As a matter of fact, we are doing nothing of the sort; nor do we intend to. But do we explain the situation to him? The practising physicians have not had the opportunities we have had of meeting and studying health problems. True, we send them a good deal of literature, but they are overburdened with reading matter now.

With a little co-operation a good deal can be accomplished. Let me illustrate; in Prince Edward Island there had been no systematic vaccination of children for some years in the rural schools. Eighty-five per cent of our children were unvaccinated. This year I started a campaign. At first I feared it would be a failure, but I wrote the physicians and requested them to go into certain schools and do this work. They co-operated wholeheartedly, and while the campaign was not a complete success, the extent to which it failed was due to no fault of the physicians.

Now I came to the third point I mentioned—the education of the public. If our students get the public health point of view the solution will more readily appear. We have, in the medical profession, a body of teachers who can handle this work; certainly they can assist in it. If there is better co-operation between the physicians and the public health authorities in the control of communicable disease more of the latter's time would be available for the purpose of teaching in the schools and otherwise. It is all a matter of mutual understanding and co-operation to carry on an effective program of education.

If the student has the preventive view point, if there is better co-operation between health authorities and practising physicians, and the public receives more education along the lines of public health, the cost and difficulty of preventing disease will be greatly lessened.

The Chairman: I am sure we have all found it very interesting to get these reports from the different provinces. Representatives from the other provinces were asked to speak, both on the preventive side, from the health officers, and then on the therapeutic side, from the practising physicians. Unfortunately, some of the provinces are not represented on either side. I do not think it is wise to stop at this point for a discussion, but to pass on to therapeutics, because the talks we have already had have dealt not entirely with the preventive side, but have reached into the therapeutic side. On the other hand, possibly those who are to deal with the therapeutic side will reach back into the preventive; so we will have the discussion at the close of the afternoon program.

We are now to have an address from Dr. Kenneth A. MacKenzie of Halifax, N.S. I understand that Dr. MacKenzie, who is Chairman of the Program Committee, wishes first to make an announcement.

(2) Therapeutics

Dr. Kenneth A. MacKenzie (Halifax): The announcement I have to make is that the Program Committee met and they wish it to be known that any member who has any communication to make to this conference to-morrow and who is not already on the program, should first communicate with some member of the committee.

Mr. Chairman and gentlemen, I have been asked to introduce the section dealing with the therapeutic side of State medicine. There are several reasons why I should be brief. The first is that some things concerning this subject have already been mentioned by previous speakers. The second is that we in Nova Scotia have not touched at all on the therapeutic side of State medicine. It has never been discussed in our medical societies nor in other circles, nor has the Government of the province discussed it so far as I know. It is not a live question in Nova Scotia. I, therefore, have nothing to say about the therapeutic side of State medicine from the point of view of experience. The third point is this, and it is the most important of all, that some of the speakers who are to follow me come from the West; and they have studied this question in great detail and are therefore much more competent than I to give you information of interest. Any observations I make, therefore, will be of a very general nature.

It seems to me that in our present system there is a distinct evil or defect which requires a remedy. That evil may be briefly stated, as I have often heard and seen it stated, as follows: that in our present system a certain class of people cannot get what medical science has to offer them at the market price. Medical science, as we all know, has made tremendous strides in the last twenty-five years and the problem of diagnosing a case correctly and treating it efficiently is an expensive business.

If I wish to investigate a case of obscure fever or obscure abdominal pain, it is necessary, after making a careful examination, to refer to various diagnostic procedures such as the X-ray, laboratory tests and so on. The result is that the expense connected therewith is very great.

Now, the poor man gets this service in the public hospital for nothing or next to nothing. On the other hand, the rich man is well able to pay for it at the market price. But about sixty per cent of our population, I should say, belong to a class whose earning powers are small and in order to balance their budget they cannot afford these expensive forms of diagnosis and treatment. They are too proud to accept them for nothing, and they are intelligent enough to want to get the best that medical science can offer.

Now, if there is an evil there must be a remedy, and that remedy, as I see it, must be some form of distribution of cost among the people at large. That brings us to the term "State medicine".

I do not think anybody means by "State medicine" a complete service such as we had, say, in the army, where everybody comes under a certain law. It calls for some form of disposition of cost for those services which cannot be paid for by a large percentage of our population.

We have in a measure some forms of State medicine now. We have the State supported hospitals, we have the Workmens' Compensation Board and the Sick Mariners' Fund. These are examples of State medicine. Some industries have a local form of State medicine. In Nova Scotia in the colliery districts we have also what is equivalent to a form of State medicine. So that any scheme which may be evolved will simply be an extension of some of the things which are already going on in our country.

I must confess, myself, that I cannot see the solution of our difficulty clearly. But I was very much interested during my recent trip to Western Canada in observing the activities of the people out there. We read with great interest what they have done in British Columbia, Alberta, and Saskatchewan and I think that the work which was started out there, and which may develop into something worthwhile, will gradually filter through to the more conservative East. I have faith that the medical profession will solve this problem, and in the end solve it well.

I now give place to my friends from the West.

The CHAIRMAN: We are now to hear from Dr. George A. Ramsay.

DR. GEORGE A. RAMSAY (London, Ont.): Nationalizing medical practice would rationalize therepeutics. In this premise there is a degree of application feasible in the subject theme and a measure of possible attainment of the objective. Nationalizing medical practice is only to be inferred as being a protective subsidy by pooled interests to make medical attention obtainable by those needing it, and is in keeping with precedents well known, *e.g.,* international steamship lines, national railroads and provicial hydro electric developments, etc. All these agencies are known as public utilities. Medical service is a public utility—subsidies to public utilities are allowed so that results may be enhanced, and this I am convinced would follow from an adaptation of National Health Insurance to medical practice.

The physiological dose of digitalis will not be changed by nationalizing medical practice, but a national plan of health insurance might help to rationalize the use of this remedy by providing a cardiograph for the average patient who takes the digitalis.

The subject apportioned to this paper is "Therapeutics" under national health insurance. This implies the giving and receiving of a medical service between two individuals in an active and a passive relation of patient and physician. The fundamental interaction of these two is based on a certain psychology and a definite economic need. I shall try to carry through this idea in what follows. If, in the developing of the situation, it may appear as though dream castles were being evolved into a medical millenium, it is to be understood that the evolution is not to be the work of the moment, but, rather, the recognition of what would be an ideal, only to be reached through the years—or, perhaps—never.

From the patients' standpoint of economics, there is a need for insurance against loss of time through sickness and its attendant drain on his resources. Insurance is a habit and that habit is growing and extending into new fields—hence the variety of policies giving various protections—burglary, fire, education, annuity, etc., etc. No difference in principle exists between any of these and health insurance—except that the latter is more likely to be called upon and thereby benefit the insured.

The economic need of the patient is that he shall have assured himself of being able to meet the financial obligations of sickness. In the present generation, we find that most people have obligated themselves to purchase on deferred payments to the extent that their income is mortgaged eighteen months in advance and that no provision for sickness is included, or else, the immediate demands in certain family circumstances are such that it is impossible for them to provide for medical service either now, or in the future.

The economics, as far as the doctor is concerned, is that he should receive a fair return for services rendered to each whom he served, without having to cover his losses by extra premiums on those who are his financial assets.

There is then a growing opinion that health insurance must be increasingly developed to meet the economic needs of the generation. I can agree that it

would be a justifiable governmental measure to require it and if necessary provide it for all whose income falls below a certain level. I am not sure but that above this level, it might be wise to offer it, as a voluntary act, to the individual who chooses to accept. It would seem to be in keeping with the best interpretation of the word democracy. Certainly, governments are more likely to legislate for masses than for classes; and it would seem a fair thing that they should pioneer the principle of national health insurance since the unit of national prosperity is the producing individual.

National health insurance is not State medicine—and any attempt to make it such, over the whole country, would not be accepted whole-heartedly by either public or profession. State medicine as contemplated or operating elsewhere, follows much the same division of duties and responsibilities as the military and naval medical services. The occasion for such in the general population of our country has been only the rare one of war. Exception to this is found in certain of the Canadian provinces where definite specialized conditions of industry and settlement require a modification of such a State Medical service, and it operates generally with efficiency and satisfaction but nowhere is it purely State medicine. Its claim is economy and inclusiveness, both of which may be otherwise obtained. Where civilization is further advanced and its complexities increase, the relations of one individual to his fellows determines the procedure of business, government and social service. Herein lies the psychology that determines that will for individual freedom of choice and selection. The essence of this is that the insured public shall have the right to choose their own physician. This reaction is the source of each present day physicians' clientèle, and this is imperative to carry into any considered scheme that may vary the present conditions of practice.

On the side of the physician, the same psychology of the individual will holds, and it expresses itself in the desire to do our best work under the stimulus of competition. The physician profits by giving satisfaction. To make him merely a cog in a great machine cuts the ground from under this great driving force of human action.

Now, at this point, we may assume for the sake of argument, that national health insurance has been instituted and in operation. It would have been made actuarially sound and satisfactorily financed for the extent of services offered, the details of which do not concern this paper. Freedom of choice of physician elected to serve the individual has been granted and the group so centered about the physician constitutes his insured clientèle or if you will permit the use of the word his "insured group" practice. Let us suppose also that the entire country elect this type of medical service.

The work of such a hypothetical "insured group" physician would divide itself into

(1) Preventive therapeutics.
(2) Curative therapeutics.

So that under an inclusive country wide scheme of insurance, every condition of public health or individual indisposition would come first under his ken.

What conditions must reasonably pertain so that he may work satisfactorily?

(1) He must be fully equipped in the matter of education and training to give satisfactory service within the scope of the routine of ordinary surgical, medical and obstetrical conditions. This is the business of the universities and in Canada is fully assured. Further, he must continue through the years to maintain or increase the standard by which his responsibility and capability shall be accredited to the public. This would seem to be the business of the licensing bodies. Satisfactory office establishment is a detail that can be accepted as secured by regulations that would not be controversial.

(2) He should be adequately reimbursed for present work and from that income maintain a pension fund that will retire him from insurance practice at a reasonable age. The basis of this is actuarial.

(3) He must have what help he needs when such help is desirable or essential. This would reasonably include all the auxiliary means of arriving at a diagnosis or carrying through treatment which is beyond the capability or opportunity of the general physician. This means that all diagnostic services of whatever variety should be freely available without extra cost to the "insured group" patient and unrestricted to the call of the physician when reasonably required. This principle is operative in our present Workmen's Compensation Act," where the principle has proven sound. If for accidents, why not for sickness? In other words, the pathologist, bacteriologist, radiologist, consultant, druggist, dentist, nurse, hospital and operating surgeon would have a place in the ultimate scheme of National Health Insurance. I recognize that it may be a far vision, but it is an ideal.

Granted these conditions, what would reasonably be expected to be the role of the physician. His consulting room would be largely a clearing house and much of his work routine, in each of which there is opportunity for much good work and likewise for some shirking, depending on the individual.

The insured patient tends to come early and often in which there may be both advantages and disadvantages. There is at least an opportunity presented for real preventive medicine, the stitch in time, with the added satisfaction that for such service there is a sufficient reward, something that does not pertain in the general practice of to-day. The real test of preventive medicine lies in its ability to obviate depletion of the pay envelope by avoidable loss of working time. Something of this will undoubtedly be accomplished, in short-circuiting minor infections and traumas, avoiding potential dangers in overstrain of cardiac muscle, and in many other ways getting things early. Your own experience will extend the catalogue almost indefinitely. Undoubtedly curative and preventive therapeutics will be inter-active in much of the routine of office practice. The ultimate end of such a service to the community ought to aggregate very considerably in the interests of national economy of man power, increased longevity and race betterment.

It is in the application of curative therapeutics that the pinch of economic need is often felt by both patient and doctor with too often the regret that essentials of diagnosis have to be left undone. The present and commendable attitude of governmental bodies is to extend this privilege through Institutes of Health in the province of Ontario and other similar agencies in the western provinces.

It is not beyond the bounds of reasonable supposition to expect that this essential diagnostic service might be extended to all ancillary diagnostic methods. This will include not only pathology, serology, bio-chemistry but radiology and cystoscopy and bronchoscopy. These aid stations should be centered throughout the country, so that they would be within reasonably easy distance of travel.

I believe that everyone has a right to the full limit of investigation of his or her physical condition. Such a boon would bridge the gap that falls short of thoroughness in that large group who are of that most reserving middle class who take no charity and honestly try to meet their obligations. Under national health insurance the doctor would not be faced with the question "Can they afford it?"

This brings medical practice more within the true meaning of group medicine without entailing the objection that scientific investigation increases the cost to the sick person or causing them to feel that they are being shuttlecocked from one physician to another. No matter what the extent of such

investigation, the final responsibility shall return to the source, the national health insurance physician, and the active treatment indicated by the several findings should remain within his province. It should be the duty of medical organization under any plan of national health insurance to see to it that the office of the panel physician did not become a mere clearing house and that the physician did not degenerate into a rubber stamp passing on the responsibility to others. This criticism is justly urged against the present operation of the panel system in Great Britain, especially among those whose one purpose is to capitalize their popularity. This and other evils of a system of national health insurance can certainly be regulated if we keep an open mind to the oportunities for both failure and success. The plan in Great Britain is based for the physician's remuneration on the assumption that in ordinary times the attendances average four per person per annum, and that three of these are office consultations. Lloyds offer an "Anchor" plan of insurance against the need for payment of fees to the general practitioner and place the premium at four guineas per annum in a family of four. They also offer additional insurance against operation and hospital costs at an increased premium of about twice the other. The plan is similar to what we know in sickness and accident commercial policies but our premiums are considerably more. These are based on a relatively small number of policy holders, and it would seem reasonable that the provincial Governments might subsidize the scheme to the extent, that while the plan was being worked out they might protect the policies and make good the deficit until a sound actuarial basis was developed on which to apportion the cost to the individual and other assisting agencies.

The phase of national health insurance in Great Britain that has been extended since its inauguration is that of the consultant. Evolution of their plan has demonstrated that the place of the desired consultants in the several specialties is an essential need and its regulations permit to a certain degree what we may describe as group medicine. The end sought is that the patient may benefit from substantiation of diagnosis and outline of treatment without the hopeless handicap of extra expense which he is ill able to meet in the circumstance of sickness.

At this stage, we may infer that the needs of the great majority of cases will be met; but there remains the proportion whose urgent need will extend to hospital management or trained nursing in the home, and the services of the operating surgeon.

This is the point where caution would dictate, that advocates of an initial scheme of national health insurance should move slowly, but for the unprotected individual, it is even a greater consideration than the matter of diagnosis alone. Certainly, in the scheme in its broadest outlook, some definite place must be given to the availability of hospital or nursing care for those whose needs demand it. Our Workmen's Compensation Act admits this contribution—likewise certain commercial insurance agencies demand that the injured under their jurisdiction should be brought to their own re-habilitation centres for expert treatment.

Further cost to the head of families where sickness comes, lies in the charges made for medicines and sick room supplies. It is reasonable to expect that these should be available without the inclusion of profits to the extent that are frequently added.

If then, any proposal for a scheme of national health insurance will permit of the required hospitalization of the sick individual or the acquiring of such other surroundings favourable to his recovery, then, I believe, you will again supply from your own experiences the answer to the question as to a greater possibility and a more effective thereapeusis than though the doctor had to struggle on with inadequate facilities and indifferent support.

By and large it is the writer's opinion that a consolidation of contributions, individual, industry, and state, into a pool for national health insurance, would effect in the end a commonwealth of attainable health for the Nation.

NOTE.—The foregoing is an attempt to consolidate the reports of the Inter. Relations Committee of the Ont. Medical Association and also to crystalize the discussion evolved therefrom at the Round Table Conferences of the past two years.

The CHAIRMAN: We are now to hear from Dr. E. J. Boardman of Winnipeg.

Dr. E. J. BOARDMAN (Winnipeg): Mr. Chairman and gentlemen, it was not by gold or by silver but by labour that the entire wealth of the world was originally purchased.

Our Dominion is wide, from sea to sea, from the glorious east to the golden west; but from the moment the light of the rising sun begins to brighten the rock bound shores of Nova Scotia until its last ray has faded from the highest peak of the Rockies as it sinks in the west, it has not illuminated one single acre where a weakling could exist alone, unaided. It has spread before our eyes a panorama of great variety and wondrous beauty. It has shown us a sleeping giant of gigantic proportions and stupendous possibilities; when he awakes who can say.

Canada is a strong man's country—strength of body, strength of mind, strength of will are demanded for its development. Only the strong may hope to overcome the lethargy of this sleeping giant and arouse him to the exercise of his latent possibilities and so whether our seas or our mines or our forests ask for our mountains, our prairies or the long lonely trails of the north, the answer will always be, our greatest asset is strength and our greatest need is health.

I am not in the camp of those who believe that ill health, disease and disability are inevitable. I believe that health is in the germ cell, that that vital principle of life which has survived these millions of years of evolution is not easily perverted. These million years that have passed give me a million reasons for confidence in the integrity of this germ cell which needs only a suitable vehicle to express itself as a perfect specimen. But if the individual is sired by an unhealthy sire, harbored in an invalid womb, and begotten in the atmosphere of poverty and disease, all must admit the physical handicap.

In our benevolence we are spending time and money lavishly on our wrecking crews, who rush in with all modern equipment and with the utmost celerity clear up the debris of catastrophy. In direct contravention of nature's law of selection which demands that only those shall survive and reproduce who have the physical stamina to stand the gaff of their environment, we are pampering the weak and inefficient to maturity.

I imply no discouragement of the benevolent, or disparagement of the unfortunate, but merely wish to point out that wrecks are expensive and to suggest that if our benevolence compels us to care for and raise those unfortunately unfit, our common sense should demand their elimination, if not by death, then by some other means less objectionable to our sharpened sensibilities.

Does it not seem logical that if the greatest need of the state is health the greatest effort of the state should be directed toward securing that commodity? Should not our common sense dictate the necessity of a national policy of health assurance sufficiently broad in its scope and liberal in its terms to include every individual?

One points with pride to what the State has already accomplished for the care of its people en masse by the eradication of epidemics, by assuring the purity of the food and water supply, by the disposal of sewage and along many general lines. This has been wonderful progress perhaps, and at least has been responsible for the survival of many thousands who would otherwise long ago have been eliminated from the combat with their environment. It means

that the State is doubly responsible for their existence. That they are swimmers in adverse currents, that the State distinctly owes them a measure of individual attention throughout life, that having caused them to survive, it should continue to assure them the health that will keep them useful citizens. Surely these are facts which are hard to deny, but to the doctor whose vocation in life is dealing with health problems both individual and in the group they should appeal with great significance.

By using the knowledge that is common stock among medical men to the best advantage of the nation as a whole, by applying our efforts to the health of the nation in the future as heartily as we have applied them to the individual in the past, I am positive, that in two generations Canada could produce a breed of men, a brand of physique and a national health record that would astonish the world.

The laity does not understand, the public does not know, therefore it is the duty of the doctor, the man who does know and understand, to advise and protect.

But, you say, just how may the doctors do all this?

By doing three things.

(1) By advising and securing for the people a block signal system in the journey of life operated for the care of the health of the individual, the safety of the community and the benefit of the State, the disregard of which shall entail severe penalties.

(2) By making such arrangements as will assure every doctor and every patient reasonably convenient access to all modern facilities and laboratory technique which may be necessary for a diagnosis, without immediate consideration as to the cost of same.

All of which means that sickness is in no sense a private enterprise, and that the disablement of the most insignificant appearing individual, young or old, is something in which the whole State is immediately and vitally interested, and his restoration to efficiency something that equally concerns each and every member of society.

(1) This Block Signal System means that at stated intervals, for the benefit of his own health, for the safety of the community and the prosperity of the State, each individual young or old, rich or poor, shall stop for a thorough check up and overhaul, I would like to say mentally and morally as well as physically.

If a periodic examination has been demonstrated to be good business for the life insurance companies with their selected risks it should prove infinitely more profitable to the State which is compelled to take the run of mine.

Instead of taking business away from the profession this block signal system materially adds to their work, substantially raises their pay and increases the number of doctors needed. Instead of going to the patient the patient will come to the doctor thus conserving his time and energy. It means he will be paid for his services instead of working ten hours to be paid for seven. It means a great reduction in the total amount of sickness and disability and a proportional increase in the per capita wealth and producing power of the State. It means the inauguration of a new specialty, one that should appeal to every practitioner in the land, the best one yet conceived, that of keeping well people well.

(2) In regard to the care of the sick let us divide the people of our Dominion into two large groups, those who have sufficient means to give adequate attention to all their sickness and disability, and those who have not. And for the sake of being specific let us say that a man with an annual salary of $3,000 comes in the first class, and a man with a salary under $3,000 comes in the second class. For the purpose of this paper let us say that those in the first class will

do all that is necessary for their disabled under all circumstances, which will not be exactly true. In the second class come, I would guess, the majority of our citizens; that section of our population whose strength of body and physical fitness constitutes the capital from which we draw the alert minds, the skilful hands and the power of endurance which goes to make up the backbone of the development of this Dominion.

If an individual's usefulness to the State could be expressed in percentages, this group would contain all grades, from those whose efforts are worth 100 per cent down to those who are barely breaking even and whom we might designate as 50 per cent and then comes a great heterogenous mixture of folk who for one reason or another just don't keep up with the traffic, who are a drag, a hindrance, impede progress, and the cost of whose maintenance presses heavily on us all.

Much of their sickness and disability is the result of inadequate care.

Much of the inadequate care is due to ignorance, carelessness, poverty, and delay in seeking advice and is found among this lower 50 per cent. But a deplorable amount is also found among those who rank as our best citizens, who come between the 50 per cent and 100 per cent, who are among the real producers, and the difficulty may not be called poverty but the justifiable hesitation, the laudable consideration of an honest man who is paying his way, about plunging into an expenditure which he can not be certain will yield a satisfactory result, and which he knows will in either case cripple him financially for years and possibly for life, whose little surplus cash is tied up in a mortgage on his home, let us say, which is the result of the labour of years, which is largely the provision of a provident man for his old age, and which he will lose.

We should be broad minded enough to see that it is extremely unfair to ask this man who is doing his best and is an asset to the State to make this great sacrifice for the rest of us.

We hear a great deal about the high cost of medical care and a great deal of criticism levelled at the doctors is being broadcast over the land in which we are being portrayed as monopolists who are bleeding the poor, fleecing the well-to-do and generally adding to the burden of life for all classes.

It looks as though we are being hoist by our own pétard. In the last three decades especially, doctors have devised many wonderful aids to diagnosis and the treatment of disease, many of which are very elaborate and proportionately expensive. From the richest to the poorest the public have been educated to appreciate the value of these developments, and cannot be censured for demanding the most efficient up-to-date methods for the care of their sick. The fact that the application of these methods is a great burden to many is certainly not the fault of the doctors and will not be remedied by simply reducing doctors' fees. It means much more medical treatment than that.

May I ask some questions which you need not answer just now?

Do we admit that much of the permanently impaired ability that exists is the result of inadequate care?

Is it not true that most of the inadequate care is due to ignorance, carelessness, poverty, and delay in seeking advice?

Is it a fact that there are 400,000 people in Canada who cannot afford the cost of medical care?

Is there any reason our intelligence can accept as good or sufficient, why each man or woman who graduates in medicine should with his or her diploma be handed the responsibility for the gratuitous medical care of 500 citizens of this Dominion?

Should the burden of the cost of medical care be carried entirely by the recipient? You may say, yes. But if he is absolutely, or in part, unable to

meet the expense of this service, may the whole or any part of his deficit with any semblance of fairness be considered a justifiable charge to the profession of medicine?

How may these various burdens be equalized?

By adopting a nation-wide policy of health insurance.

Which will distribute the cost of medical care equitably over the whole community.

Which means that every individual in this Dominion throughout the whole producing period of his life will contribute monthly toward the care of sickness and disability.

Which means that the improvident will be compelled to provide.

Which means that the word "charity" will be completely removed from association with the care of the sick and the stigma of pauperization absolutely detached from the treatment of disability.

Which will locate and treat disease in its incipiency.

Which means the registration of all sickness.

Which will reduce the national total of sickness and disability by 50 per cent in ten years and 75 per cent in twenty years.

Which means the removal of the responsibility for the care of the sick from the shoulders of the few men who happen to be doctors to the broader shoulders of the State.

Which means that instead of treating 400,000 people for nothing doctors will receive $1,000 each annually for doing it.

Which means payment on a per capita basis.

Which implies free choice of doctor by patient and patient by doctor.

But you say this is "State medicine," and I say "State medicine" is only a name, a bogey to frighten doctors with.

We have had State medicine in part for many years.

Assuring ourselves of our national health is common sense.

Dr. D. S. Johnstone (Regina): On receiving a communication from the General Secretary of the Canadian Medical Association, asking me if I would contribute something to this congress on the subject of health insurance and perhaps because the time was short, I made a too hasty decision and replied in the affirmative. Later on, when I had time to consider what would be of interest in the study of health insurance, and particularly the therapeutic aspect, I began to realize what a very difficult subject this is to discuss. We can always sit around the waiting-room at the hospital and exchange views upon the practice of medicine, and easily get into an argument as to the relative merit of this or that type of applied medicine, and its effect upon the profession and the patient.

I do not believe there is anyone in Canada who has worked out a complete set of ideas which could be fitted into a system, more or less complete, of State health insurance or State medicine.

Sometimes it seems to me that we use the term "Health insurance" because we dislike to even suggest State medicine, although I observe that the Deputy Minister of Health raised the question at the Congress two years ago. Having carried on under a fairly complete system of State medicine for several years during the Great War, I must confess that the term raises no terrors for me, and in passing I would suggest that when the time comes, some valuable information may be obtained by a close inspection of the methods of the Canadian Army Medical Corps. However, that is not to the point at the moment. What we are now supposed to consider is the therapeutic aspect of health insurance, or if I found a correct definition of therapeutics, the study of applied medicine, under some system where the cost of treatment is maintained in some way other than by the individual paying the shot or I should say as much of the shot as his circumstances or his honesty will allow.

For several years I have been acting as chairman of the Committee on Municipal Physicians for the Canadian Medical Association, and each year have endeavoured to collect something from the opinions that prevailed in each of the nine provinces concerning the propriety, value to the public, and the physician, or otherwise, of this method of health insurance. This committee by the way owed its origin to the fact that a doctor in Saskatchewan wrote the General Secretary inquiring as to the ethics of this method of selling one's services to a municipality. The questions asked seemed to stir up the whole matter of the municipality or the State engaging the services of a doctor in a capacity other than that of a preventive health officer, and in consequence the Canadian Medical Association struck this committee, which has been in existence since the date of the Victoria meeting. While obtaining the views of the other members of the committee and likewise doing some thinking and observing for myself, I was forced to certain conclusions. For instance, we already have a great deal of health insurance, and I do not refer here to individual life insurance, but to health insurance in the mass, and likewise a considerable amount of State medicine, and again that both are steadily increasing. Then one must decide if this is something that is satisfactory to the profession and good for the public at large. Is the change from the purely individual type of applied medicine, to this mixed type of part health insurance of some kind and part State medicine of some kind, the right way to bring about a change and is it going to end in a fairly unified, fairly complete system which will prove quite satisfactory and work to the best interests of all concerned.

It is a most difficult study, I believe, but as it appears to me up to the moment, I am more than in doubt about it, indeed I would fear rather bad results for the profession, if we allow all these conditions to continue on, without undertaking to guide some of them and completely head off others.

Before continuing further in the discussion of the matter, I would just mention here that our Municipal Committee recommended that a commission be sought for to make a long and careful survey of all the realm of applied medicine, and that such commission should have the assistance financial and otherwise of all our Governments, federal and provincial, and I may say that a start in this direction has already been made in British Columbia, whose government at the last session named a commission for this purpose. Also, I believe that the next session of the Legislature of Saskatchewan will see such a commission struck, with the object in mind to make a complete study of all health questions. The Alberta Legislature also has had the question of the advisability of State medicine up for discussion. The other provinces so far as I know have not yet reached the point where the discussion has appeared upon the floor of the legislature, but that, I expect, is but a matter of time.

Further, in this connection we have to note the studies made in health insurance from the mass standpoint that have taken place in all the provinces in recent years. To use our own province of Saskatchewan as an illustration would serve to point this out. We have there a Rural Municipalities Act which makes provision for complete State medicine in so far as the rural districts are concerned. Three years ago there were some sixteen doctors carrying on under that Act, while to-day there are twenty-seven. Some are satisfied, but most of them I believe, and this opinion is gauged upon inquiry, would prefer something different if the financing were as secure.

At the last session of the legislature an Act was passed—the Sanataria and Hospitals Act—whereby the government gives free treatment to all afflicted with tuberculosis. This removes quite a large part of the practice of medicine over into the health insurance and State medicine column. Also provision has been under way since then for free treatment of venereal diseases. These changes are steadily limiting the field of practice on the one hand and increasing the

amount of practice which may come under the heading of health insurance. Again we have pending a new Workmen's Compensation Act, which is now awaiting completion and proclamation, having been passed at the last legislative session. This Act contains forty-eight pages, and is very broad in its scope, having room within its boundaries for the care of all labourers in so far as their health changes are affected by their work, and fraught with great possibilities, I should think, for further expansion along similar lines. Indeed, one can easily visualize such an Act being so elaborated as to become a superstructure upon which to build one system of complete state medicine as is suggested, I believe, by some at least as a possibility in the Workmen's Compensation Act of British Columbia. Those already enumerated are the chief items in the program of the present evolution into health insurance or State medicine in our province. Added to these, of course, are many minor ones. The Red Cross Society, which raises its funds from the public at large, does a great deal of work for the more or less destitute families, and principally for the sick and crippled children. I am proud to proclaim that the medical services in practically all these cases is rendered free, medical, surgical or whatever it be. The District Medical Society which embraces Regina names a committee annually to serve with the Red Cross Executive in allocating cases to the different medical men, all of whom are willing to do their share in this free service. I say I am proud of the profession for this, but I know at the same time that it is all wrong. These cases should all be charges of the state and the doctor be paid reasonably for his services. In addition also, amongst the minor movements towards health insurance should be mentioned—The activities of insurance companies, church societies, sick benefits of fraternal or benevolent societies, clubs and so on, all of which must be considered as factors in the movement, which up to the present has no guiding hand, and whither headed, no one knows, but certainly already causing much anxiety to the hard-working public servant or slave, the general practitioner in medicine.

There is an old saying that "There is nothing new under the sun." This is probably as true in medicine as in anything else. Certain it is that down through the ages, attempts were made at different periods to establish medicine in some system of health insurance. Notably amongst these was that of Peter the Great of Russia, which failed perhaps because medicine was not then far enough advanced as a proved science to resist the assaults made upon it from the ranks of superstition and doubt. Lately we have the Panel System in England, sponsored in its inception by Rt. Hon. David Lloyd George. Whether the panel system of applying health insurance is as successful a one as could be desired still seems to be a subject for conjecture. What information I have obtained concerning it, for which I am indebted to Dr. Neville Challenger, recently Pathologist at the Regina General Hospital, if correct, would lead me to believe that there is much to be desired as yet. Medical insurance, medical benefit or the panel system as it is variously referred to in England, was established by law in 1911 and replaced almost entirely the old system of club practice. The service is under the direct authority of the Minister of Health and therefore the nominal head is the Minister of Health. The Executive Department proper is housed at Roseberry Hall, London, and the Council at Whitehall. The functions of the Council at Whitehall are, to prepare from time to time and to put into force regulations governing the conduct and practices of the service. To consider from time to time and to seek enactment of all improvements of services suggested by the Executive Committee. To formulate standard pharmacopoeias, medical and surgical appliances and to pass these on to practitioners who are members of the panel. To act as a court of final appeal on any question of misdemeanor in practice,

neglect of duty, etc., on the part of any panel practitioner. To consider and pass judgment upon any grievance of an insured person or on a question of malingering on the part of persons attached to a panel. Specialists in the various fields of medicine and surgery are also retained at specialists' fees, attached to the Council at Whitehall to act in an advisory capacity, relative to the above matters. Similarly, there are district specialists in local centres throughout England, Scotland and Wales.

The executive proper under control of the Secretary of the Panel Committee, a medical man, is housed as stated, at Roseberry Hall. This department embraces various sub-departments, a few of which are in charge of medical men, but the greater number are directed by laymen. The duties of the Executive proper are as follows: To deal with the enrolment of all panel medical practitioners and to make payment to them of quarterly dues for service rendered. To review, file and comment upon medical records of treatment, death, etc., of all insured persons, returned periodically by each practitioner. To assign insured persons to the doctor chosen on notice of such selection being given by the insured. The Executive selects and approves of insurance companies with whom those entitled to medical benefit may insure. All matters involved in the insurance of persons entitled, returns by the insurance companies, etc., are reviewed by the Executive at Roseberry Hall.

How this medical insurance is effected does not properly fit into this paper, but it might be of interest to mention that the cost is borne by the employer contributing about three times as much as the employee, and the government contributing a sum equal to the sum of the contributions of both employer and employee.

I do think, however, that if an attempt is ever made in this country, or in the provinces, to collect into one system all the many enterprises, now, or that may be in the future engaged in applying some form of health insurance to the public ills, at that time the assistance of the best business minds that we have should be engaged in working out the financial end of it. The profession might largely be left out of that phase of the movement.

There is also not time or space to include at this time an account of all the intricacies of application in this system, only to say that in a sense the insured person has a right of choice as to which panel doctor he or she may come under or be attached to.

Before leaving the panel system of Great Britain, I would like to draw attention to some of the evils or abuses which were pointed out to me in connection with it, as to the insured on the one hand and the doctor on the other. It is maintained by some, who are well informed, that it tends to break down the morale of the individual. Under the regulations, he may secure sick benefit in addition to unemployment benefit and thereby secure enough to live on. This opens up the opportunity for malingering in the way of pretended illness, and when his panel doctor refuses to give consideration to his claims, he has himself transferred to another panel until he is successful in finding someone who may accede to his wishes.

In regard to the profession, the element of competition is quite removed, which may be bad for the enterprise of the physician. Also, he is faced with the possibility of losing so many of his panel if he does not agree to requests wrongfully made, as to jeopardize his livelihood. At the same time, he sees so many patients a day, often not needing attention at all, that he comes to treat them in a machine-like manner and gives little time or attention to study or to the individual case. Then too, he is compelled to use the standard pharmacopoeias, appliances and so on set out by the Executive Committee and here again his individuality is lost and he becomes more of an automaton than ever.

It is impossible as already stated to go into the panel system fully enough in the brief time allotted to this paper to point out all the possible evils which might arise out of it, but I feel sure that a careful study of it will show anyone, that in all its ramifications the actual practice of medicine suffers greatly, and the attendant evils far outweigh the good either to the insured or to the physician who operates under it. One outstanding proof of this is the fact that very many, who while compelled to contribute to the system and who nominally appear under some panel do not make use of, but engage and pay for a doctor of their own choice. This will account for the large balance shown by the Panel Committee, which was given to me at approximately £25,000,000 in 1926.

What has been included here in connection with the health insurance or medical insurance system of Britain, is not for the purpose of criticism. Indeed, I am fully aware that much might be told to offset any apparent criticism which may appear. Our purpose, however, is I take it, to work out our own salvation, not with fear and trembling, but with the fullest confidence that if we do but treat the subject in a fair and impartial manner, there remains only the other factor, time, until a satisfactory solution is reached.

Some one may be saying about now that this is going too far and almost assuming that we are about to step off, jump off or dive off into State medicine or oblivion, or something of the sort. Not so, but at the same time those best informed at the moment are satisfied that legislation is pending in some of the provinces, which look at it however you will, can only result in the state tying up to some, more or less complete, form of medical, or health insurance. The people want it, at least they want some measure of relief from what they now consider a great burden, and I believe they are convinced it can be obtained and they still secure as good or better care than now. I have become satisfied of this myself during the past three or four years that I have been acting on the Committee of Municipal Physicians. Others, probably much better informed than I am, are equally convinced. I am sure Dr. J. H. MacDermott thinks so. He has contributed greatly to the discussion of the question during many years, also to this conference on Medical Services at its first meeting. Likewise Dr. H. E. Young, Provincial Health Officer for British Columbia, Dr. McCullough of Ontario, and many others.

I know that in the older provinces the feeling may not be so intense, but still it is there just the same and sure it is that if the western provinces adopt a health insurance scheme, it will soon spread to all of Canada, and I would voice the opinion that the federal Government should form some sort of alliance with the Provincial, if and when the movement gets under way.

Before attempting to place before this meeting some ideas which have emerged from my more or less periodic contemplation of the health problem, I would like briefly to attempt a survey of the field as we have it now. In looking over the report of the last conference, I observe in the different papers the frank intention to expose what may be considered, perhaps, not as being wrong, but we will say, not just working in the best interests of medicine, with many excellent and clearly thought out suggestions making towards a remedy. Soon I think those who have graduated into the position of leadership must sit down and co-relate the whole. To illustrate that, I will but mention one paper given on public health cost. There is a collection of figures to delight the mind of the habitual statistician, but to me it fails entirely of accuracy, because in my opinion you cannot reasonably take anything representing the cost of public health but the sum total of all that is spent on education for public health purposes, medical faculties, etc., all treatment both by regular physicians and quacks, all hospitalization, all money spent on patent and proprietary medicine, all nursing costs, even all dentistry, and moreover the cost of all societies and organizations developed for the advancement of health and the care of the

sick, and the cost of all research for medical purposes. Within these bounds what have we of interest at this time and to this conference. Let us take first the subject of Education. What criticism or suggestion I may have to offer here, or elsewhere, will not be considered as that of an expert, but as coming from one looking on things from the standpoint of the general practitioner. I would submit that we are educating too many now that we lose to other countries, and again I would submit that we are educating many to work in this field of service who, if not a menace to the science, would at least be much better in some other line of endeavour. Take our hospitals—I can speak at least of the system of establishing municipal hospitals, and ask you to consider the serious menace to the community these may be and indeed often are, under the present unrestrained type of competitive practice—much surgery is being done now because it is easy—surgery which creates the necessity of more surgery, gynaecology, and more medicine as well. Take even our best hospitals, as good as anywhere I believe, but again consider the mounting cost, might this not be greatly augmented under another type of practice. I think most certainly it could in hospitals with open staffs. Recently W. J. Mayo, speaking on hospital work, used these words: "Hospital expenses have risen to a point where only fifteen out of every hundred persons find the outlay no cause for worry. At the other extreme are fifteen wholly unable to carry the burden who under any likely scale of charges must be classified as charity cases. In between are seventy individuals, usually in what might be termed moderate circumstances. Ten of these seventy find specified institutional expenditures somewhat disturbing, and another ten while they can pay something, cannot pay their physician after they do so. There remains a group, comprising at least half the total population, which finds the cost of hospitalization and nursing a burden, which it can meet, if at all, only by a very considerable sacrifice." Although this may not apply entirely to Canada, it surely does to a great extent.

Now consider the nursing problem. I believe that the Canadian Medical Association already considers it one. So far as the medical profession is concerned, I should say that nursing is out of control. I would hesitate to define what relationship the nurse of the day bears to the medical profession. Here again, under a different type of practice, I think the situation would be much improved and better results obtained at a greatly reduced cost, and by that I do not mean by lowering the remuneration coming to the individual nurse. Consider our research institutions, not nearly extensive enough, not sufficiently close to the applied field.

Consider the purely medical field, the indefinite condition that reigns there. The flood of proprietary and patent medicines, with the enormous added cost to the public and the consequent empirical type of prescribing which it engenders. Under a successful change would not this situation be greatly altered for the better. However, greater than all else I believe the attitude of the average practitioner towards his fellow in practice and to his work would likely be very much better. This is a difficult subject to discuss publicly, but I do believe this, that a competition in attainment would supersede one, which at present, one might safely say is based largely upon less noble aspirations. In this connection, I can conceive of a situation where to a major degree the men entering medicine will be those possessed of the finer qualities of mind and heart which enables the individual to put aside the temptations sordid and mercenary, and serve for the sake of the service. I am sure that under such a system there would be less temptation to enter, for those actuated by other desires and more worldly aspirations.

What should be said about the business side of practice as now constituted? I am quite sure at least, most will agree that it is unsatisfactory. The great

financial burden of charity seems now to rest largely upon the doctor. How horribly unfair this is is very well known to all who have spent many years in practice, and needs no elaboration here. This burden should be completely eradicated under a proper change in the system of practice. Some may not think so, but I fail to see how it could be otherwise, and one more evil, not I believe the least, I beg leave to mention here—many will protest that this is a vanishing evil—I think they are, to use a slang expression, "Kidding themselves." As long as a cause remains usually the effect is in evidence. I speak of the antagonisms which have always and always will continue to fill a large place in the lives of those competing under conditions as we know them—antagonisms which embitter the lives of many and must render them less useful servants and citizens. This, I believe, if not eliminated altogether, would shrink to insignificance. Leaving the profession for the moment—What does the public get under our present type of practice? As I understand his ever-increasing demand, at least as expressed in our part of the country—he wants two specific changes, which will enable him to obtain in his own district, or close to it: First: As good an interpretation of his condition and as good treatment for it, as he can obtain in more distant fields. Second: That his bill for health shall be very materially reduced. In doing this, can it be done under a new method of applied medicine which will still retain for him a considerable amount of that intangible something which is generally understood to go with his relationship to the family physician, and is this as necessary as some of us think—under the present existing conditions of society?

After all, to whom does the science of medicine belong? And for whom does it exist? The answer to both questions, I take it, is "The people." Maybe some of our traditions are outworn, or should be revised. At any rate should not we for the sake of the people, at least take stock of our profession from all aspects to determine if anything can be done, any move made which will give to the people at less cost, a more complete service in public health care.

At the same time the public should be prepared to deal fairly and generously with those willing to spend their lives in so exacting a service. There is no other occupation which demands the sacrifice and the risks that are bound to come to those who labour in the practice of medicine. He has to be an all-weather man and stand up to all kinds of exposure to disease. And, morever, to share the sorrows of those who are bereaved.

Let us assume then for the time being that rather radical changes are pending—or perhaps better to say, should be considered. How may we go about to produce them. Take first the consideration of an elaboration of the Workmen's Compensation Act, as suggested from some in British Columbia. It offers some sort of framework for a rather extensive Health Insurance plan, and as has already been mentioned, so does the Act now awaiting completion in Saskatchewan. Next, one might consider the extension of our present Public Health Departments along such lines as have been started in Quebec and Saskatchewan, only I would say on a different plan, making health divisions throughout the province served at strategic points by hospitals, which would then lose their present menace by being properly staffed and served. Extension of the educational side of medicine, including scientific research, should be developed to a very great extent so as to bring the individual health unit, the doctor to as high a standard as possible. This I consider of primary importance, both from a scientific and economical standpoint. By increasing the efficiency of this unit, and in that way only, can you expect to finally rout the armies of infection and so reduce enormously the general cost of health. The evidence of his efficiency will be seen in all the associated enterprises that make for health—sanitation, cleanliness, good food, good housing, ventilation, physical culture, and so on.

In my opinion, this would be the best method, with probably provincial uniform laws, so that there would be little, if any, friction and so that the Dominion Department would act in conjunction with all.

Thirdly: There might be undertaken a complete new scheme, which would appear unnecessary and might too greatly disrupt what we have already.

Lastly, we may drift along from this to that as we are now doing—until we are all either specialists, parasites, or occupants of the poor house—with the public getting a more and more indifferent type of attention.

The question has been raised, would the present effort on the part of philanthropic individuals be lost under a state medicine system. I do not see that this would necessarily follow.

The present system of extension of education by the Canadian Medical Association, whilst a step in the right direction, does not in any way in my opinion offer the best means for postgraduate continuance in the study of medicine, which opportunities could best be supplied by extension of institutions of learning and research, intra-provincially. I again suggest that the surest method to reduce the cost of health is to reduce the number suffering from disease or injury and to greatly enhance the usefulness of the individual physician.

In conclusion, I would pass on to this conference some ideas and suggestions —most of which probably are not new, and no doubt in some form or other the subject matter will have occurred to many here to-day, but to bring them again to your attention may serve to suggest some thoughts for discussion which will assist in making clear the whole situation.

As a summary I will put them to you in the following manner:—

Can applied medicine be improved upon by making certain broad changes in its method of application?

If so, will it not be best to investigate the possibilities in the fullest possible manner?

Is the demand for change so insistent on the part of the public as to make resulting legislation likely in the near future?

Whatever change is to come, if any, should it be introduced through the medium of the medical profession?

Does this conference consider that sufficient evidence is to hand that the public can be much better served by a fairly competent system of health insurance than it is being served at present, and at a greatly reduced cost?

Are we satisfied that these changes can be produced in such a way as to greatly benefit the medical profession?

Dr. W. G. Anderson (Wardlaw, Alta.): I have been asked to speak upon the moot question of State medicine, the request doubtless coming to a man from Alberta because of the publicity given throughout Canada to the interest and aggressiveness of our local government in the matter of health legislation and health activities. The threat (or promise) of an extension of these activities would appear to loom larger and more imminent on the horizon of our province, perhaps, than elsewhere in the Dominion.

I have been asked to confine my remarks to the therapeutic aspect of the question or subject, but I freely confess I am at a loss to define just where the province of Hygiene ends and that of Aesculapius begins. The line between the two has been worn so thin it has now almost disappeared. Does the removal of diseased tonsils, as carried out by our government travelling tonsil clinic (of which more anon) merely eliminate the condemned tonsils, or does it also prevent in many cases the arthritic and cardiac conditions which may follow in many cases if enucleation is not carried out? I shall, however, endeavour to confine myself to that phase of the problem which is usually considered curative, though we must bear in mind that therapeutic measures if applied early and

successfully prevent prolonged illness, complications and possibly further spread of contagion. This prevents loss of time and earning power of the patient and often saves those dependent upon him from privation, with its attendant woes.

As a preface to my remarks it might be well to give a resumé of the legislation pertaining to health matters in Alberta, which have been passed since its inception as a province in 1905.

At the first session of the first provincial legislature in 1906, an "Act respecting the Medical Profession" was passed. This act embodied all the supposed valuable features of the medical Acts of the older provinces, and under it the first College of Physicians and Surgeons of Alberta was established and the first provincial council elected.

From time to time at the request of the profession, or on the Government's own initiative, certain amendments have been passed which on the whole have been beneficial to the public as well as to the profession.

Among various acts dealing more particularly with the physical wellbeing of the people might be cited the follows:—

(1) City, town and municipal Acts, making provision for the appointment of health officers, for the medical and hospital care of the indigent sick, and for the prevention or eradication of contagious diseases. Provision is also made for a nursing service in the outlying areas of scattered population.

(2) Workmen's Compensation Act, providing medical, surgical and hospital care of workmen injured while engaged in industrial occupations, and in addition giving them compensation on account of physical impairment, or loss of remunerative employment.

(3) Municipal Hospital Act, which permits a group of municipalities, after a vote of the ratepayers, to erect or purchase hospital buildings and equip and operate the same by means of a hospital tax levied on the real estate, thus enabling the sick to obtain hospitalization at the low rate of $1 per day. The tax in support of these hospitals is 3 cents per acre, or less.

In connection with this Act it is now proposed in some quarters that the powers of the board be increased to enable them to employ on salary a surgeon to serve the people of the hospital district.

(4) Mental Disease Act, providing for the custodial care and medical treatment of the mentally unfit or narcotic addicts, all at the expense of the family concerned, if they are financially able, or by the State, if conditions are otherwise.

(5) Venereal Disease Act, which provides for local centres where competent officers give free treatment to the unfortunate persons afflicted with disease.

(6) School Act, providing for the medical inspection of all school children at the expense of the school district, out of the regular school tax.

(7) Sterilization Act, under which a competent board, after the patient has been properly inspected and being found mentally unfit, and his freedom from custodial care being a menace to the public, may order the patient sterilized.

(8) Act *re* Medical Specialists: This Act provides that no registered medical practitioner may hold himself out to be a specialist in any line unless and until he has satisfied the University of Alberta that by training and experience he has the necessary qualifications for the special work he wishes to undertake.

(9) Act *re* Rural Health Centre: This provides that a group of rural municipalities may by a vote of the ratepayers concerned establish a health centre with a full time medical health officer, sanitary inspector and nurses for the prevention and eradication of infectious diseases. This includes public school health inspection similar to that at present given to city school children.

(10) Travelling Clinics: These were organized by the Department of Public Health primarily to give a health inspection, a tonsil, adenoid or other minor operation, to needy children in the unorganized districts where no nursing or medical services were readily obtainable. These services having been found popular in certain districts, have been extended beyond what was at first contemplated. A nominal fee has been charged where those conducting the clinic deemed advisable, but the clinics have not been self-sustaining and the deficits of $10,000 annually have been paid out of the general revenue of the province.

The extension of these services into more thickly settled districts in close proximity to resident medical men raised a storm of protest, but the fact remains that these defects in many of the children were not being corrected and that many receive attention who evidently would never have received it through the ordinary channels.

(11) Municipal Doctors: The Government has undertaken to provide medical services in the outlying places where without some guaranteed revenue no physician, without being otherwise financially independent, could undertake the work. It is understood the Government provides the salary; the district, the residence; and the family concerned, the transportation. How successful this will prove cannot be stated, as it is only in its first year of trial now.

(12) The Professions Discipline Act: The Government has passed an Act whereby a board composed of representatives of various walks in life sit in judgment upon the acts of members of the profession, and from their judgment there is no appeal to the courts, but only to the board which renders the first decision.

At the last session the legislature approved and appointed a committee to inquire into and report upon the various systems of State medicine. This action was in response to the urgings of labour and farmer organizations, who feel that our system of bringing treatment to the sick is inadequate to our present day needs and conditions.

While discounting the emotionalism which characterises the demands of a somewhat clamorous percentage which always ally themselves with movements of this sort, it will not be sufficient to dismiss their demands as "lay twaddle" or hold up our hands in horror and shout "state medicine," "standardization of medicine," "medical bureaucracy," or "pauperization of private patients." Someone has said that in the three-sided relationship of patient, doctor, and hospital, the patient is the helpless corner of the triangle. The medical profession must be alert or perhaps the physicians will find themselves occupying the helpless corner of this most interesting geometrical figure.

While the foregoing are the principal acts dealing with the health and physical wellbeing of our people, many other acts and amendments have their bearing on the question as well, but enough is given to show the position the health of the community occupies in the minds of the citizens of Alberta.

With all this somewhat far-reaching legislation you may wonder why there should be any demand for a further extension of services—some of our people going so far as to demand a complete system of State medicine, which, as ordinarily accepted by its proponents, means the establishment of a system whereby all the people can and will obtain adequate treatment. This demand gets its most intelligent expression from the so-called middle classes, who realize the wealthy can now obtain modern scientific diagnosis and treatment because they can afford it, and that the indigent can obtain the same because they can't afford it.

The respectable industrious farmer and artisan is often denied this service unless he is willing to become a helpless and hopeless debtor, and loses not only his financial freedom but also his self respect.

Will Hayes once said: " Things don't happen, they are brought about." In order that you may understand conditions and how they were brought about, I consider it necessary that I give you a brief outline of the history of the political life and movements in our province during the last few years.

In 1921, owing to real or fancied unequal economic conditions, the farmers entered politics and gained control of the government. They became class conscious and joined hands with labour which had long been also class conscious.

The medical examination of recruits during the war had just revealed the fact that the men from the country, though living an active life in the fresh air, with plenty of milk and other fresh foods, were of inferior physique. Naturally, it was asked why—and the most reasonable answer was that the city people had the advantages of prenatal care, baby and school clinics, and other various health services with all their attendant advantages. The people from the rural districts considered their contribution to the State was such that they were entitled to similar services, and this may explain at least in part their demand for an extension of the field served by the travelling tonsil clinic.

There are other contributing factors which would appear to bolster the reasonableness of their desire for a greater measure of State medicine:—

(1) *The Isolation of Some Districts.*—This has been an important factor. The governments, both Dominion and provincial, have assisted in building railroads into districts where the traffic would not warrant their construction at the time of building. They are called pioneer roads and future developments are expected to later on justify the outlay. If the State considers it the part of wisdom to do this, would not a pioneer medical service where the traffic would not itself support sufficient medical men and hospitals be also the part of wisdom. Is business to receive greater consideration than health?

(2) Some of our members of the medical profession were unacceptable to the public because of overcharges, lack of skill and, I regret to say, some were dissolute. The remedy for this lay in our own hands, but to make doubly sure we would apply that remedy the Professions Discipline Act was passed, and also the Specialists Act.

(3) The apparent success of the Workmen's Compensation Act. If this can be administered successfully it is but natural to think it could be extended in its scope with advantage to greater numbers.

It is interesting to note in passing that the farmers, who are themselves large employers of labour, especially at certain seasons, have carefully avoided being brought within the scope of the Workmen's Compensation Act.

(4) Education is recognized as a duty of the State—why not health? While the objection may be raised that uniformity of service is impossible it might be pointed out that we do not have uniformity in our postal, educational, or taxation departments.

(5) We already recognize our duty to care for the mental defectives and our narcotics, both in the field of prevention and therapeutics.

(6) There is already much State medicine as evidenced in the Sterilization Act, Venereal and Tonsil Clinics and Municipal Hospitals Act (the government gives a per diem grant per patient as for other approved hospitals). We have lodge and contract practice. We have prenatal, pre-school and school clinics, and now we have the move for periodic health examinations, which is a further extension of these agencies to cover the whole period of adult life.

Briefly that is the condition and the state of mind which confronts us in Alberta. We have as citizens brought all this about, or have as physicians had much of it forced upon us.

Dr. Freeman of Johns Hopkins says in referring to public health aids:

"It is somewhat surprising these movements should have advanced so far toward complete realization without more general recognition of the basic idea which is in process of evolution. Perhaps it is typical of the genius of the Anglo-Saxon peoples that we fail to consider the broader and physiological aspects of a problem while actually engaged in working out the details which will finally bring us in effective reality to the consummation of an ideal."

And, remember, that in Alberta, we are not altogether guided by Anglo-Saxon genius.

It will not be well with us if we close our eyes to the fact that the trend is toward at least a general enlargement of the various services already being given in the civilized countries of the world—or perhaps to the extreme where every conceivable form of medical and hospital service will be rendered to every citizen without specific fee or charge, by civil servants trained in medicine and nursing, all at the expense of the State, or, in other words, "the creation of an organized system of continuous medical supervision to replace our present unorganized and discontinuous plan of medical service."

It would appear it is for us to consider some means whereby a considerable section of the public will bear their own health burdens while at the same time contributing to a free service to the rest of the community—which contribution is now made largely by the medical profession alone. We must as citizens assist in solving these problems and endeavour to bring to their solution the comprehension of the difference between sound thought and visionary speculation.

Those who have had practical experience in operating public health services appreciate the difficulties and dangers of rendering efficient medical services under government auspices. The difficulties now encountered in carrying out our work in its limited spheres under government auspices would rapidly increase with the size of the organization and size of population to be served.

A single organization serving a province or a nation is to-day unthinkable. Perhaps it is our destiny to assist in the evolution which can only reach its ideal development when we have an ideal people. People must be educated concurrently in health matters as the interest of the State is stimulated. In other words, the extension of medical services should be coincident with the public enlightenment, or as Dr. Biggar told us at our last conference, "that advances in all forms of human activity are completely conditional upon the willingness of the human animal to be advanced."

Are we as a profession giving our best, when the people look to us as their logical teachers, to help them to distinguish between real and spurious advance?

Many objections occur to us which might be advanced against the introduction of any extensive system of State medicine or health insurance.

(1) The cost, which would be enormous.

We have been repeatedly told that human capital is our greatest resource, that it is our greatest national asset, and figures have been produced to show that the productive value of the 5,000,000 male persons in Canada is one hundred and ninety-three billions of dollars, or five times our tangible material resources. Granted this estimate may be approximately correct, might not a government think itself justified in spending large sums to safeguard this enormous investment?

Our farmers in Alberta and also in Saskatchewan and Manitoba have gone into big business. They have built up their own marketing agency for their wheat, with an annual turnover exceeding by many millions the gross business of the Canadian Pacific Railway or Canadian National Railway. Perhaps the entry into the big business of an expensive and costly health scheme would not dismay them.

(2) Another objection is the enormous personnel.

To quote Dr. Freeman once more: "We would have a great government bureau employing thousands of mediocre physicians, who, secure in their places on the public pay roll, perfunctorily carry on the delicate and important tasks of medical and surgical care and prevention. We imagine those great organizations dominated by those politically-minded members of the profession with whose activities we are frequently so sadly familiar."

(3) Loss of individual initiative.

Already individualistic medicine is strongly threatened by three great forces: the growth of scientific medicine, the development of industry, and the rapid changes in social relationships.

The large fees received by surgeons and specialists has a fatal tendency to diminish the number of general practitioners. This accentuates the need of country physicians and the economic rivalry between medical men. In plain words, the necessities arising in the "battle for bread" has already cost us much. The aim of our profession should be to make the conditions of insurance practice, if it comes, approximate as nearly as possible to those of private practice.

(4) Dangers of political interference.

We must ever guard against baleful political meddling.

(5) Sacrifice of private practitioner.

These are some of the objections, many more will suggest themselves to you, and I hope the discussion to follow will bring them out and emphasize them.

With whatever degree of apprehension we view the question of State medicine, we must recognize the fact that there is a percentage of our people (probably only two or three per cent) who must go without medical service or accept it from private physicians as a charity, or from institutions at the expense of the public. Is this the best way to serve this class? Would an efficient medical service reduce their numbers? We must find some satisfactory answer.

Then there is another class—and a valuable class—contributing labour essential to our present social order. They perform the hard and often disagreeable work which makes possible the enjoyment of a fuller life by the more fortunate. Made up mostly of unskilled labour, their earnings are eaten up in obtaining the bare necessities of life, and they cannot afford the benefits of modern medical science when sickness or accident befall them. To obtain medical treatment they must go into debt or accept charity, with its attendant stigma. Are they not entitled to the best that we can give them as their right? We may sit back and let the sociologist and humanist employ themselves with speculations on this problem, but its proper solution concerns us as a profession very vitally.

Then we have another class in easier financial circumstances, some of whom at least consider the fees they pay are increased to equalize the lack of fees from the other two classes. Perhaps they may rebel and ask for the institution of some scheme whereby the burden may be more equitably distributed. I imagine something of this sort was in Henry Ford's mind when he established his own hospital at Detroit, though it is interesting to note he has been obliged to raise the price of services some 40 per cent above that decided upon at the inception of his hospital organization.

True the introduction of State medicine would shatter the traditions of our honourable profession, but another tradition is that medical men are scientists and the progress of science has taught the necessity of the open mind. Someone has said we must have loose-leaf minds so that we may discard the old and out

of date and replace it with the new and up-to-date, but we don't want to tear out the whole book at one fell swoop. It may be wise to replace a few pages—we must not do it because it is expedient only.

Perhaps our beliefs are group beliefs and that as a profession we think with the herd.

The man who advances new theories about the atoms is hailed as a scholar and scientist, but let him dare to speculate on human relations and we are apt to call him a Bolshevik and mark him as a dangerous individual to be at large.

What we need is not peace but perspective, not certainty, but tolerance. Equipped with these two—perspective and tolerance, we should be able to guide these new movements that threaten (or beckon) into channels which may benefit our people and wherein we would be able to say with Virgil:—

> "The very sad sights of which I myself beheld and whereof I formed a great part."

The CHAIRMAN: The papers are now open for discussion.

Dr. JOHN FERGUSON (Toronto): A great part of the burden of the so-called charity work has been laid on the shoulders of the medical profession To this there can be no possible refutation. Let me give you just one concrete example. Take the province of Ontario. We find that in the 150 hospitals of the province 175,000 patients have been treated free, medically and surgically. And allowing $10 per individual, taking into account minor and major cases, that would represent $1,750,000—a contribution as a free gift from the medical profession of Ontario; that is to say, $400 per capita of the profession.

On motion of Dr. Walker the conference was adjourned to Friday, November 22.

THURSDAY EVENING

DINNER AT CHATEAU LAURIER HOTEL

Address by Prof. STEPHEN LEACOCK of Montreal on

UNIFORMITY AND STANDARDIZATION IN EDUCATION

Dr. Alfred T. Bazin in the chair.

The CHAIRMAN: Gentlemen, a few weeks ago one Saturday afternoon after one of McGill football team's usual victories of the present season (laughter), I met our guest in the University Club. After a short time we felt a good deal better (laughter) and I asked Professor Leacock if he would be good enough to come here to-night and address us. I told him who we are and what we were planning to do in this Capital city of our Dominion. I found out for him that by leaving Montreal at four o'clock he could reach Ottawa by 7.30. I then found out that he could not get back by Friday morning as he was desirous of doing in order to continue his lectures, for the reason that the sleeper which used to be attached to one of the early morning trains has been discontinued, and it was either a case of getting up before five o'clock in the morning or staying later and missing his lecture on Economics. He decided that he would miss it. Before I left him in the club, he stated—and so far as I could see there was no special reason for his saying it—that he would be delighted to be here. I have since tried to analyse why he would be delighted and have come to the conclusion that it is because, although, as you know, he is freqently called upon to address audiences in different parts of the North American Continent, he realized that to-night he would have an audience of a very intelligent type!

Without further wasting time by empty words on my part, I will introduce Prof. Stephen Leacock of Montreal. (Applause.)

Prof. Stephen Leacock (Montreal): Mr. Chairman and gentlemen, may I ask that during the first part of my speech, until it begins to warm up to something like oratory and passion, you try to be just as comfortable as you can. I understand that you have had a pretty strenuous time, listening to one another, and the change from that to listening to me is so sudden and startling that it may be fraught with rather dangerous consequences unless you take care to settle back comfortably, loosen up the respiratory system as far as possible, open up whatever you open up when you smoke, and keep it open. I have a serious speech to make. But like all good speeches, it begins quietly and easily, and only approximates to heights of eloquence and passion, to which we are going to rise, after the first couple of hours of speech. (Laughter.)

Dr. Bazin has suggested that I evidently thought it better, or more consonant with my duty, to come here and speak to you on economics or some kindred subject than to lecture to the fourth-year students at McGill. This is merely a resemblance to the case of Sir Philip Sidney and the glass of water given to the thirsty soldier whose need was greater! (Laughter.) I can assure you that what those fourth-year students begin to know in economics is perfectly surprising. The hints they get on the stock market from their instructors will keep them poor for years! (Laughter.)

But I am here to talk to you on a question that, in a sense, is not purely economic—that of Uniformity and Standardization in Education; a thing which in its broadest sense appeals to everybody who has anything to do with the teaching profession in any field. And may I, for greater simplicity, say in two words what I intend presently to say in the course of the next three hours. In other words, when it comes to standardization I am against it. Like many other excellent things, while a certain amount of it is splendid, too much of it is a bane.

In order that there may be no doubt as to what the theme is that I am to discuss, I want to say to you to-night that in the earlier years—and I purpose traversing about eight centuries—in the earlier history of education standardization was the one thing needed. In the early history of mechanical civilization, standardization and uniformity were the one path of progress, but we have now come to a time when in this and every other country we have to consider very seriously how far we purpose going in stamping our civilization into an intellectual uniformity.

Now, as an economist, may I first explain what we mean in economics by standardization. In order to be certain of that I looked up in the new and admirable Encyclopedia Brittanica the article on "Standardization," Volume 8, page 782, and find that " Standardization" means those methods of production whereby a single and uniform process is made to turn out a large number of commodities practically identical. In that same article there is appended a very interesting paragraph taken from the Mechanical Engineering Journal of America of August, 1927, in which the advantages of standardization in the mechanical sense are amply set forth. I need not fatigue you by enumerating them all, but they run something like this: That a standardized product reduces the initial cost of production; that a standardized product renders easy the relations of buyer and seller; that a standardized product makes it possible to accumulate stocks in advance of consumption; that a standardized product—and here we come to its greatest and most splendid advantage—a standardized product has enormous advantages for mass production. And in that phrase, "mass production," you get that large and looming economic phenomenon which is the thing that is bidding fair to dominate the world. The same article tells us that standardization has gone so far that there is now in the United States a society called the American Engineering Society of Standardization, in which are represented thirty-three different industrial organizations and of

which the United States Government, through one of its departments, is a participating member.

You will be glad to learn, further, that there was held in Lima, Peru, in August, 1925—like all great men, I speak with one eye on the press and can assure you that every word I say is absolutely nickel-plated, in spite of the fall of nickel—a Congress was held in Lima, Peru, in August, 1925, and you will be gratified to know that at that Congress those present represented not only the United States but Nicaragua, Honduras, Haiti, Cuba and Liberia. We, Mr. Chairman, were not there; we are as yet pausing on the threshold of that momentous development, wondering whether we will enter the ranks of internationalized standardization or not. That Congress was such a success that it was repeated, and a second Congress was held at Washington—you will be happy to learn—in May, 1927. Again we were not represented, but, I can assure you, it only remains for the Dominion of Canada to enter whenever it wishes into this confraternity of international standardization of economic products.

Now, in the economic sense, there is no doubt as to the initial advantage of standardization. Nobody can deny it. For instance, under standardization each part of every machine that is made is equally interchangeable and adjustable, without any risk of error, to every other kindred machine. In the machines now ground out—axles and similar things of that sort—are cut to within a one-ten-thousandth part of an inch and with such extraordinary accuracy of production (a wonderful and obvious advantage which needs only to be named to be appreciated) that all the parts of every machine are applicable to every one of its hundreds of thousands of fellows.

My friend, Dr. Primrose, has been telling me to-night of a visit he was privileged to make recently to the very home of standardization, the Ford plant, out of which, he says, there now comes moving along the rails a machine consisting of an iron skeleton and wooden chassis that grows under the vision of the spectator until from the original iron, steel and wood of the mechanics and electricians who started it, there emerges at the end of one-hundred and fifty yards of rail a finished motor car, followed seventy seconds later by another just like it, and with an endless vista of consumers waiting for them.

Now, you may say that when it comes to standardization in mechanical production there is nothing to be said against it. The expert knowledge of those who produce these standardized commodities is destined to spread—standardization is going to travel from the United States, where it started, to every other manufacturing country of the world. It must be so; it is the world's way of doing things.

But you will notice, also, that you do not get any advantage in this world without somehow a corresponding disadvantage. I am sure we all feel a sort of wistful regret toward the craftsmen and the melodious blacksmith who have disappeared from the countryside; the skilled mechanic whose joy was in his work and who made something all by himself, every bit of it; who was in the Greek sense a poet, a creative worker in iron and steel. Possibly, however, we can supply him in some other way.

Moreover, standardization even in the mechanical sense, and apart altogether from such wistful regrets, also carries with it peculiar and strange disadvantages. The number of the kind of things that we are allowed to use is lessening. Do you know, for example, that there used to be, only four or five years ago, two hundred and seventy-two different kinds of sets of Pullman car dining-room china. There are now only sixty-five! (Laughter.) And those of you who are conversant with hospitals and who go about from place to place have noticed, have you not, that the number of kinds of hospital beds is diminishing year by year. Ten years ago there were seventy-two kinds of hospital beds in use

in the United States. There are now only four. As to shoes, you will be glad to learn—well, I do not know, perhaps sorry to learn—that the number of kinds of shoes that you can buy offers nothing of the wide variety known to the generation before us. Twenty years ago there were three different major grades of shoes, divided up into a number of varieties which numbered altogether—I am speaking by the book; every word here is guaranteed—which numbered some 2,500. The makers of shoes in the United States have now only one grade (grade is a technical term which I will tell you about later), divided into a hundred varieties. Arithmetical computation, therefore, shows you that what was 2,500 different varieties is now reduced down to about 100, which means that the consumers are now all wearing very much the same kind of shoes when they go out; and, if accident develops, lying and dying in very much the same kind of hospital beds!

Here, then, is the picture of the obvious mechanization of our industrial civilization. All this I do not purpose to criticize; but the question for the thinking man is, What are we to do when the same forces begin to invade other fields of activities?

There is an intimate connection, is there not, between various cultural activities and sheer mechanical production so that standardization must inevitably pass from things that are made of iron and steel and wood to things of the mind, the aesthetic things, the things of the soul. I take the most conspicuous, the most obvious example of standardization—the moving picture industry. Now, here is a strange kind of industry, to my mind the most fascinating thing to contemplate in all the world. And it came to us in such a queer fashion—unknown, unsought, a child of accident, it had to grope its way into recognition. Few realized what the moving picture of 1895 or 1896 was going to be thirty years later. Most of us here, I imagine, can remember the first moving pictures. Wonderful they seemed, and yet one looked at them once or twice and that was all—the mystery was gone. One saw, for example, Italian cavalry jumping over a fence, and one said, "How wonderful!" or a train passing at full speed, and one said, "How marvellous!" And then came a sense of disappointment, that, after all, a train passing at full speed in a moving picture was not altogether superior to a train passing at full speed over, say, the Canadian Pacific Railway.

But presently the moving picture took to itself a new language. It said, "I am going to be the vehicle of art; I am going to portray stories, personalities, people." And the Americans had the singular advantage or good fortune of being first in the field. Looking back now, of course, it is easy to say that somebody in the British Empire should have got busy.

What does the moving picture industry need? It needs first of all a perfect winter climate, where it is a fine day every day; and it needs a peculiar kind of universal scenery where you can have the forest and the sea, and the sands of the desert, and the city, all adjacent, and within access of a few hundred yards. And somebody in the British Empire should have said, cannot we find such a place as that? Cannot we start what is going to be one of the major industries of the world—but we never thought about it. And the United States, having California, started the moving picture industry and have built up out there a mass of standardized technique, with huge apparatus and settings almost impossible for us to duplicate. Now we can look in vain to the climate of such a place as Cape Town, where the sunshine rivals that of California, where you can have a mountain, desert sands, a city, and a dense forest only a hundred yards away, or other vagaries of climate and scenery easy to be arranged. The British Empire had all those advantages for a moving picture industry, which has become the most standardized, the most complex, the most typically modern industry, whose powerful influence is beginning to stamp itself all over the world in response to what is, after all, a sheer economic technique.

A moving picture is a stranger among the arts. There is no one single person who can encompass it. The day of the poet and painter is gone; in their place is a huge apparatus that can move only at the bidding of the capitalist. The human mind in its artistic aspect must keep exactly in pace with the mind of the capitalist who is looking only for dividends. There is here seen not only a strange transformation of creative art to meet mechanical and financial conditions, a shifting of values, something queer and strange that has come into the world; something that we cannot control, in which the artistic product is intimately dependent upon huge standardized technique.

But the moving picture is only one example of this trend—the greatest, and the most obvious. With it you can take ever so many other things. Take the press as another example of standardization. The printing of newspapers has now become an enormous standardized industry. You can hardly preach from any other platform. It has to be big; it has to have that terrible thing called mass production, for mass production alone can keep it going. Take the huge Sunday newspaper running to nearly one hundred pages. Mass production alone can spread abroad the standardized editorial; mass production alone can distribute the beautiful standardized humor which every Sunday goes out to the best minds of the community. (Laughter).

When I was young, Mr. Chairman, and was first able to sell a joke to the newspapers, one newspaper bought one joke at a time, price one dollar. I can well remember when I received my first two dollars for a two-dollar joke—the warm flush of pride with which I realized that with industry a gifted man by that means could make at least ten dollars a month; a thing which proved perfectly true and possible. But now, no newspaper would think of buying one joke at a time for one paper—not at all. One joke must be bought for fifty, sixty, two hundred newspapers. The whole business has, as it were, been standardized and turned into a vast "mass production." The editorials, jokes, stories which we read have all been submitted to this same process of mass production. That means, of course, that they must suit all consumers, or as many of the consumers as possible. Where to-day is the spontaneous prompting of the human mind; where can be found an ear to listen to it? Nothing save the voice that can control and command in some way that extraordinary and vast apparatus.

You might say that by this means we see and hear the best; but do we? We only hear the most conspicuous, the one with perhaps the last increment of value, or perhaps some accidental blaze of superiority which is heralded, but which may be merely so much veneer. What we have is a huge "mass production," a system of standardizing certain people and saying to them, sing to us; play for us; act for us—and "us" in that sense means the mass of the consumers; not the highest in taste necessarily but the most numerous.

Now, the thing is spreading all over the world. The world is in the process of being, shall one say, Americanized. For the word "Americanized" really means standardized: and it is only because the United States became the first standardized country that we seem to be watching what we regard as the Americanization of the world. The same forces would have brought out the same thing everywhere under similar conditions. The result is that we are in great danger of taking on as the keynote of our civilization a deadening uniformity. And if I speak of the United States to-night it is not in any way to denounce American ideas or institutions, I mean only that this thing came to them first and can best be studied in their Republic.

Of late years it has been my good fortune to travel many times to the United States as a lecturer, and I find that everywhere I go, unless I am careful to carry in my pocket the name of the city that I am in, I usually forget it; unless I make a particular note of the name of the society to which I am lecturing, it is very hard to remember it; and as for the individual people, it

is not worth while trying to remember them. (Laughter). I get out of the train and am met at the railway platform of these cities—they are all the same —by a standardized committee, the chairman of which makes the same inane remark, "Cold, isn't it?" I reply, (in my mind) "Yes; I knew you'd say that." I am driven uptown in a standardized car—one of those which are produced every seventy seconds—to a highly standardized home, where I am received by his equally standardized wife. She does not need to tell me that, of course, she belongs to the Ladies' Local Reading Club and I know that she had heard Hugh Walpole lecture. (Laughter). You will recognize in all respects the type of charming, amiable lady I mean; you have all seen her in the movies playing the part of the "heavy mother"—that kind of person. In that hospitable group I spend a short time and discover that their hospitality has also been standardized. I am then taken over to a meeting where I meet a highly standardized chairman, who is the same as all the others—I can't tell the difference. He, in turn, introduces me to a committee whose names I try to remember but cannot—they look absolutely alike; they have all been to Yale or Harvard—it doesn't matter—and in their presence I deliver a highly standardized lecture. General Currie once said to me, "You must need to get up an awful lot of lectures." I said, "No, sir; so far it is just the same one." (Laughter.)

Well, gentlemen, there you are, I may say that so far all that I have said is merely the introductory part of my address. I now wish to turn to the bigger question of the standardization of education, for that is what you have come to hear about. But now that you see the general intellectual process to which I have referred, perhaps my introduction has not been too diffuse or altogether in vain. To what extent are we willing to apply that mental process of standardization? To what extent are we willing to build up a scheme of education which is going to make people all the same?

To judge that, let us turn back a few moments and look over the history of education for the last one thousand years. (Laughter). Now I meant this lecture to be what is commonly called "a scholarly performance." (Laughter). I wanted it to contain what is called "a wealth of historical material." So before I got on the train I went to the library at McGill and got out "The History of Oxford University," in one thousand pages, but I could not read it. Yet even after a casual glance at that wonderful book, written by Mr. Mallett, I was able to draw an instantaneous flashlight comparison between education as it was when our universities started and education as it has now become.

We may take the Oxford Colleges, so Mr. Mallett says, as having more or less originated in the thirteenth century (in the reign of Henry III), and trace them down, so he says, until they reach something like effulgence in the Tudor period three hundred years later. During that time these colleges seem to have contained a great number of students; oddly enough, more students then than now. Estimates differ. The largest estimate that I can find is 60,000. Even the smallest and most conservative estimate gives 3,000, so that here you have colleges that are evidently carrying out a wide amount of teaching and, we will suppose, getting some kind of results, since some people stayed there as long as thirty years—that terrific length of time was apparently necessary to the full ripening of a Doctor of Divinity. True, there were some ardent minds who scraped through in twenty years for that degree, but such a performance was looked upon as rather hurried. (Laughter).

Now, it seems strange to think that all through three hundred years in that queer place, Oxford, with its little collection of buildings which had arisen and to which students came, although Heaven knows why—that in that time there was not a single examination, not one. Can we as college men imagine how people could have got on from generation to generation, from decade to decade,

without having any examinations? The students came and listened to lectures; they held disputations, in Latin mostly; they went through all kinds of exercises, some spontaneous, though more or less regulated, but with nothing of what we think of as system. I am not praising the results; I want only to draw your attention to the odd contrast between then and now. Not only were there no examinations, but more strange still, no text-books, for printing had not yet come to illuminate the world. People had to rely upon their memory. The professor at college had some books but these had been copied out in pen and ink and were few and hard to come at. The professor told the students what they contained. He had, perhaps, a copy of Aristotle taken from the Arabic, and out of that Arabic translation of Aristotle's Greek, he lectured.

Now, when you look at such a situation as that, of course you marvel that any real intellectual results could have been achieved, and I am free to say that from our point of view the intellectual results were probably very small—strange, misty, queer productions, a mixture of Aristotle's Greek, Latin superstition, and Heaven knows what. Such was the learned world in those unstandardized days. And if you looked at that system your one idea would be to introduce into it something of what we call order and method, a series of examinations and graded courses, etc. And such things did begin to come after printing was invented and when the Tudor period had swelled the coffers of the university; something like, I will not say uniformity, but something like system begins to appear. But from then even right down to the nineteenth century there was nothing of what we would think of as an orderly, regulated, standardized education. In a sense every college taught as it thought best, and every student learned as he thought fit to learn. There was infinitely more variety and spontaneity and infinitely more, perhaps, of total failure to learn anything. But such as it was, that was the system that built up the more or less learned world of England. One wonders at such university students as Isaac Newton, who made no mark in any school that he attended and little if any mark even at Cambridge—no mark until the time arrived when he began to work out results by processes not taught him by his teachers. Indeed when you look at the Shakespeares, the Bacons and the Newtons, other great ones of the seventeenth and eighteenth centuries, you begin to realize that, somehow, these wonderful and learned men reached their goal without any particularly great educational system.

Yet system was needed, and, of course, when the nineteenth century dawned, with its modern commerce and wealth, education had then begun to straighten itself out. I need not remind you that with the nineteenth century we began to have the state control of education. Not in England first, but in Prussia, in Massachusetts, and in the rising colonies. Here in Canada the state set its hand on education and began unconsciously to fashion and shape it, though they did not yet know the fatal word, " standardization." You have read of the English schools. Everybody knows of Squeers. It was in England, with its queer incompetent schools of the nineteenth century, that examinations were introduced, when such a person as Mr. Matthew Arnold could be made one of the Queen's examiners, in order to see that all through England a series of examinations should be held as a sort of preliminary qualifications. It was about that time, in the middle of the nineteenth century, about the time when Matthew Arnold flourished, that you have a system of examinations and of graded knowledge. To Lord Macauley we owe much for what was done. He was one of that new generation which began to worship the principle of standardized examinations. He set his mark on the Indian civil service as one of the chief products of the system. In England, in Canada, and more than all, in the United States, this process went on until presently there was a whole system of education. Everybody pointed to it proudly—and quite right; they could not see its difficulties. In fact, there were no difficulties in it

for a long while; it produced wonderful results in the mass. Only here and there was a voice raised in protest. Some of you who have read political philosophy may have heard such a name as that of William Humboldt, the Prussian statesmen and philosopher, who bitterly opposed state schools, and thought they were stamping out something of human individuality and spontaneous endeavour. Humboldt's voice was as one crying in the wilderness—and he was wrong anyway, because in the early nineteenth century the advantage to be gained by system was ever so much greater than any possible disadvantage which then could come from uniformity. There was, I repeat, very little of disadvantage until right toward our own time; we are only beginning to see it now. But the world in which we live moves fast and the thing that was a small cloud presently obscures the whole sky; the danger that was negligible when you and I were young may be one of the major dangers of our intellectual outlook at the present time and such, in my judgment, is this thing called standardization in education.

We have been anxious to make provable qualifications; we have been so anxious to make the entry into the professions a matter of provable merit that we have been trying, as it were, to cut and dry every such performance, to indicate exactly what the subjects of knowledge are and to leave almost nothing to the individual spontaneity of the teacher and the pupil and of the particular town or place; until now we are building up on this continent a huge educational machine similar and interchangeable in all its parts from Maine to California, from Halifax to Vancouver, with the inevitable tendency that every teacher is going to be like every other teacher; every text-book is going to be the same kind of text-book, findable everywhere all over the continent.

In relation to that question of text-books, there is in Canada a marked tendency to try to make our text-books uniform; to get, let us say, one good arithmetic and use it all the way from Prince Edward Island to British Columbia—one good one, the best that you can get. I want to say to you that in my judgment two bad arithmetics are far better than one good one, and, if it comes to that, ten bad ones would be better still. (Laughter) Just at the moment when you get arithmetic or history standardized in one book and recorded in one way, even though it be the very best way you can find, you have fallen away from the earlier knowledge, in which there were half a dozen good, bad or indifferent kinds of histories. Just at the moment when you have introduced a set type of school-books which you think universal, you have, as it were, struck a vital blow at the roots of scholarship; you have killed off the thing which, after all, started and made scholarship—the individual product of the individual mind. If you look back over what we know of history, you might fairly correctly say that history has been made more by people of exception than by the mass. I know that this is a disputed point with analysts. Some people tell us that what we call the man of exception is the mere product of the mass movement of the crowd. Others will have it, like Thomas Carlyle, that the whole movement of the crowd is dictated from above—that the literature of England is made by the Shakespeares, Bacons and Kiplings and not by the unnumbered millions who attended the board school. If this is true, our ideal system of education should be one which somehow or other puts as high a premium as possible on individual variation and initiative.

I have been in touch with teaching at McGill for almost thirty years. During that time, I regret to say, I have seen very little of individual genius. It may be there in latent form; I am only saying I have seen little of it.

Yet when I look back to what I remember of the geniuses that went before us, the people that we can remember as grandfathers and friends of our grandfathers, queer old characters of the countryside, this person and that, I recall that they had about them a variety and diversity, a difference of individuality, that I think we are losing. Where, I ask, are the freaks that I remember when I was young? (Laughter)

Let me here pause to lay emphasis on the social value of the freak, the man who is different from his fellows, who, through some queer oddity that is in him, does not purpose to conform to the ideas, the manners and methods of those about him but who has his own way of doing, saying and being things. The person whom we call a freak may be only a little different from the Newtons and the Shakespeares who have moulded our civilization.

So that you see, when we come to plan a scheme of education we are drawn, as it were, in two directions. We want, of course, competence. In dealing with entry to the professions, we have to come down to facts. After all, we are not trying to make only geniuses, but ordinary people as well, fitted for ordinary things in an ordinary way, and we are up against such stupenduous difficulties as the question of reciprocity between place and place. In your profession, for example, it won't do, from a practical point of view, to turn out in Montreal doctors that are not acceptable in other parts of the world. You must conform in some respects to the condition which is laid upon our educational system—that up to a certain stage it must be uniform and adjustable and fit in to the educational system round about it. But while granting that we must not lose sight of the fact that uniformity always means a certain sacrifice and that unless you have a system in which the exceptional person is free to move and develop, your system carries within itself the beginning of its own ruin—it is destined to be crystallized and become ossified. At McGill, as I have said, I have seen very little of what one would call genius developed. The conditions are against it. What can genius do if you decree that all must pass such and such an examination for matriculation. No one ever said that to Isaac Newton or even to Dr. McCall, president of Toronto University three generations ago. There was then no iron-bound law of matriculation, no measured, standardized step that everybody must take. The moment you have done that, what can genius do? What about the boy who says, 'I love history,' if you take him on the very threshold of his endeavour and say 'No, you cannot write history until you have learned a modicum of this and that.' Why, by the time you have imposed your standardized system for seven or eight years, gathered up your forty per cent of achievement, there is nothing left in him of spontaneous desire; the mind is formed, the boy is standardized, he is turned into a committee man only fit to receive me when I go to make a speech. (Laughter)

These things are especially applicable to us in Canada. There is no country in the world upn which is laid a greater responsibility than that which rests upon the people of Canada, and no class of Canadians whose burden of responsibility is so great as that which rests upon the shoulders of those of us who are fashioning, through education, the mind of the country. We have here a Dominion of which we used to boast in a half-hearted way, trying to make ourselves believe that it was really as wonderful as we could have wished; and, lo, before we realize it our dream is coming true. With every fresh discovery and every new asset brought to light we are beginning to see the reality of what is going to be the heritage of the Canadian people; we see what it is going to mean—a civilization that can be embraced within our three million square miles of territory and our marvellous and almost untouched resources. Those among us who are technicians and engineers are doing their part. There is no lack of technical knowledge in Canada, no lack of the pioneer spirit. If there is a lack, it is in the imagination of those who are to control the mental destiny of this country. The time has come in Canada when we should try to make ourselves something not only different but greater than the civilization of other countries. We do not need to take our pattern from anybody; to model our education on that of any other people. We should walk our own path and see that it leads high; in no spirit of unfriendliness to other nations or other educa-

tional systems. We must think out for ourselves what we are going to be. We should have strength and courage, and faith enough to look forward to the time when the intellectual development of the Dominion of Canada will stand as high above the rest of the continent as our splendid and untouched physical assets bid fair to do. (Applause).

Now, this has been a long talk. I had intended to put in at the end a peroration on the medical profession and say something complimentary about what you have been doing here in Ottawa. I do not know just what you have done, but I gather from your chairman that you have been considering questions that are going to have an important bearing on the future of your profession and of Canada. I congratulate you on the arduous duties you have performed here; especially, if I may say it, on the creation of that new body, the Royal College of Physicians and Surgeons of Canada. This institution which has just begun is destined, I believe, to go forward into the history of our country and fulfil in it a similar part as—and I trust even a nobler part than—the parent body from which it takes its name.

I thank you, Mr. Chairman and gentlemen, for the singular opportunity that you have given me here to-night. (Applause.)

Dr. H. E. Young (Victoria): Mr. Chairman and gentlemen, I hesitate to assume the duty imposed upon me of moving a vote of thanks to the distinguished speaker of the evening, as I feel, after listening to Professor Leacock, that I am one of those squelched geniuses, and, among other things, in such trying circumstances the gift of eloquence was killed a'borning. I should like to have had Professor Leacock direct my education, to the end that at some future time, as a student of his, I could have arisen to this occasion and expressed the sentiments of this gathering for the magnificent address which we have heard to-night. There must have been in my education in those days, something of what Professor Leacock has suggested—a crushing of potential genius, with its resulting suppression; so that, Mr. Chairman, I can merely voice what I am sure is the sentiment of you all in thanking Professor Leacock for his humorous and inspiring address, with its epilogue containing a criticism of present-day standardization in our schools in Canada which I think is deplorable.

I have had some bit of experience in a section of Canada in moulding at times a school curriculum providing for standardized rules and producing, unfortunately, I am afraid, only forty or fifty per cent men. I think, however, that in considering Professor Leacock's subsequent remarks we may feel somewhat optimistic that there is in the Canadian nation an intellectual standard that, in spite of this effort at standardization, will develop to a point that will be worthy of such a country as ours, with its enormous natural resources; that we have a stratum of developing students who will demonstrate to future generations the struggles that we have gone through and prove that we have here the energy and equipment to survive and overcome the deleterious conditions that have been sketched so ably by Professor Leacock.

Shall we take his words as humorous or serious? Certainly, there is a stratum of earnestness in them. I think we can pride ourselves as Canadians, and my prediction is, that there is a stratum among our students that will come to the top in this country notwithstanding the tendency to standardization in education described by our distinguished speaker.

I beg to move a vote of thanks to the professor for his brilliant address.

Dr. E. J. Boardman (Winnipeg): Mr. Chairman and gentlemen, in rising to second this vote of thanks for the fine eloquence to which we have listened for what seemed only a short time but which, I presume, was quite a long time, I realize that I am undertaking a rather difficult task.

I desire to thank Professor Leacock particularly for the way in which he has referred to this Dominion of ours, its resources, and the people who are in it, of all of which we are so proud.

Now, in regard to standardization, there are some things about our northern country that just fit, in one thing at least, that perhaps a few of you are more conversant with than others. As one travels in that northern country along those lakes and wide rivers which open out almost into lakes, at times one comes across here and there what we call a lob-stick, a tree that points out the way. You come along the trail to the river bank or lake shore and look around to determine just what your direction is to be in order to arrive at the beginning of the trail on the other side. If you look up you will often find that somebody has taken the trouble to whittle down with an axe a big pine, spruce, balsam or fir—one that stands out prominently, leaving only one branch pointing in the direction you are to follow.

In our north country this is known as the lob-stick. But, believe me, although the lob-stick is there and perfectly obvious to all, it took some trouble to make. Someone had to climb up with an axe and hang on with teeth and toenails while he hewed off those other branches and left the one which still survives. And so this lob-stick stands there for years pointing out the way to those who are to follow. In a similar way, and just as prominently I understand, for thirty years Professor Leacock has been standing in McGill University like the lob-stick of the north, stable but not standardized, pointing out the way as no uncertain opponent to standardization.

The Chairman: Professor Leacock, no words of mind are necessary to express to you the great appreciation and thanks of this audience.

Dr. J. L. Biggar (Toronto): Mr. Chairman, perhaps it will not be inappropriate at this point for me to say that I had the advantage in my earlier years of sitting at the feet of the gentleman who has just addressed us in so striking a fashion—now known to all the world as Professor Leacock, but whom we then knew as "Stephen". At the age of ten I went to a school in which "Stephen" was a master. I asked one of the other boys of the school, "What sort of fellow is this man that we are going to?" His reply was, "Well, he is a crazy ass!" (Laughter.) It was not very long till the fact was proved. A boy did something which offended the master and instead of being punished in the regular way he was made to stand for five minutes with the stove shovel in one hand and the poker in the other. I can see this youngster yet, weeping tears about the end of the second minute because of this terrible man. That, I can assure you, made an impression on all of the students which no ordinary caning could possibly have done.

Some years later when I was a senior, an equally unregenerate boy was guilty of a very heinous offence of chewing paper in the class. Instead of dignified reproof for this offence against decorum, hygiene and morals, he was called up to the front of the class which Stephen Leacock was conducting in French, German, or some other allied subject, and was given two large sheets of double foolscap and told to eat, chew, and masticate every bit of those sheets of foolscap satisfactorily to the master, before he was permitted to dispose of them in the waste-paper basket. Again the impression made by this unstandardized method of punishment was a permanent one.

The third story is briefer. Occasionally it happened in those days that a boy required to leave the room during the course of the lesson. A certain boy

had been given permission to go out. In his absence, Mr. Leacock went down the rows of desks correcting exercises and by the time the boy returned he was sitting at the back of the room. Coming in, and observing the vacant desk and chair at the front of the class, the lad called out, "Where's Stephen?" "Here, sir," was Mr. Leacock's instantaneous reply.

I think that it will be obvious from these anecdotes that "Stephen" practices, or at least practised in those days, what he preaches about the advantages of some deviations from a rigid standardized and stabilized system of education.

Dr. GEORGE S. YOUNG (Toronto): Mr. Chairman and gentlemen, having started reminiscences in this way, perhaps we might go on. I remember Professor Leacock when he was a student at Varsity. He insisted on taking two or three honour courses simultaneously although I did not see him attending any of the lectures!

The CHAIRMAN: Well Professor Leacock and gentlemen, we have had a pretty strenuous day and I think it would in order to rise and retire.

FRIDAY MORNING SITTING

The conference resumed at 9.30 a.m., with Dr. Bazin in the chair.

The CHAIRMAN: I will first call upon the Chairman of the Program Committee for any announcement he may have to make.

Dr. Kenneth A. MACKENZIE (Halifax): At present there is nothing to report except to say that Dr. J. H. Elliott of Toronto, who was to be called on yesterday, will be back this afternoon, and if there is an opportunity for him to speak he would be glad to do so.

The CHAIRMAN: At the completion of the discussion this morning I will ask for a report from the Committee on Resolutions. In the meantime, I will call upon Dr. Meakins to speak—I will not say introduce the subject, for that was very ably done yesterday—to speak on the subject of

THE TREND OF MEDICAL EDUCATION IN CANADA

Dr. JOHN C. MEAKINS (Montreal): Mr. Chairman and gentlemen, last evening when I reread the few remarks which I had to make to-day I felt more or less like a plagiarist, not on account of what Professor Leacock said last evening, but on account of what took place in the afternoon. So that if what I am going to say sounds like repetition, it is not my fault, but merely indicates that probably quite a few of us are thinking along somewhat similar lines.

In March, 1927, I addressed this meeting on "The Product of Our Medical Schools," and when your chairman sent me a telegraphic request to address you again, I did not know whether he wanted to catch me on some of the remarks I made two and one half years ago. So I read over carefully what I said before so as not to contradict myself. My concluding paragraph at that time was as follows:—

"So our product should leave us realizing he has but entered on a pursuit of knowledge which will never be completed and that his cultivation has been honest and sincere, with a full appreciation of the difficulties and high ideals of his profession, and should approach the future in the quest of truth with an understanding of the fallacies and errors of the

past." To this ideal of medical education I still adhere and believe it should guide our efforts in the future. I have now been asked by your chairman to open the discussion to-day on "Medical Education: Its Trend or Future."

The role of prophet is a dangerous one, not only because it presumes to Divine inspiration and may attract celestial wrath, but also because prophets have usually been targets for contemporary and earthly scorn as well. The cautious prophet is one who from the development and lessons of the past, the evils and virtues of the present, merely suggests the possible conditions to be expected, with fair reason, in the future.

Medical education and practice have usually run in tandem, education but little preceding. It is true that exceptions might be found to this statement; but, on the whole, I think it may be taken as fairly correct. On the other hand, medical research and the revolutionary thoughts of the few have long outdistanced both education and practice. It has been notorious how slowly fundamental truths and new ideas have been accepted and adopted by the medical profession at large. On the average fifteen to twenty years have elapsed between the enunciation of important new conceptions of disease and their acceptance and practice by any conspicuous section of the medical profession.

It is true this period of inertia is becoming shorter but still there is much left to be desired. In our teaching, in our text-books, and in our outlook on life in general the medical profession is essentially conservative—one might even say "die hards." This is probably to be accounted for by the numerous disappointments which we have experienced, particularly in therapy. But I often feel that many of our disappointments are our own fault as we are so gullible and accept the statements of interested parties without sufficient critical analysis of their contentions. I believe this to be due to a fundamental fault in medical education. This fault being the so-called dogmatic or oracular method of teaching which is looked upon with favour by so many. It is "not done" to question or ask the reason why, and reminds one of the lines in "The Charge of the Light Brigade"—

"Theirs not to reason why,
"Theirs but to do or die."

One who aspires to the role of prophet may look back over the past and find much to guide him in prognosticating the future. During the past one hundred and fifty years the evolution of medical progress has been expressed in great advances which to-day we accept with quite a matter-of-fact spirit. To begin with, we have the great Teaching Schools of Anatomy of the Munroes, the Hunters, and others. Followed by the advances in anatomical diagnosis due to the fundamental work of Auerbach in percussion and of Laennec in auscultation. Both of whom, particularly the former, died long ere his discoveries were accepted. Then as was but natural, there developed the great School of Pathological Anatomy to be accompanied by the period of therapeutic nihilism The discovery of the bacterial cause of infectious diseases and asepsis made the advance of surgery possible and in medicine laid the foundation for the first attempt at specific therapy. During the eighties, nineties, and early nineteen-hundreds physiology and biochemistry were struggling after the truth but were considered of little importance in the practice of medicine until a new generation arose by whom these discoveries could be applied and interpreted. Since then there has been a tendency to delve even deeper into the origin of diseased processes and to find our explanations in the fundamental laws of physics, chemistry and mathematics. The aim in all these advances has been to elucidate the origin and life history of disease.

As physiology and biochemistry dealt with the disturbances of function rather than of structure, it was but natural that the functional manifestations should gradually assume more and more importance and that the disordered

human being should be looked upon as a going concern rather than as an interesting post mortem specimen. So the trend has been to attempt to recognize if possible earlier and earlier in its progress the beginnings of disordered function. It is true that Bacteriology opened a new field in the conception of the aetiology of certain diseases, and led us immediately to the consideration of conditions which antedated possible introduction of pathogenic bacteria into the animal body. This in turn produced the great advancements of communal public health and, coupled with sanitary engineering, has been responsible for many of the amenities of modern social life.

But the future of medicine is preventive in a much more individualistic manner than in the past. The reaction of the patient's life in the work-shop and home must be studied by his medical advisor. Much may be done to retard and even stay the progress of disease by an intelligent conception of the many underlying aggravations which push a patient from bad to worse. The careful guidance must begin in childhood in many instances. The majority of people seek to prepare themselves for their future economic existence in the most haphazard manner. It is in such matters that the physician should be trained to give guidance to those who need it. It is usually considered that occupations are either light or heavy—sedentary or manual. This is far from the proper conception of a proper occupation. Man is not only a beast of burden. His mind should also be considered. Therefore it is imperative that the "state" of the mind and the spirit should be investigated by the careful physician, as well as the heart and lungs. This is best taught in the wards of the general hospital. A careful survey of the cases admitted there reveal the fact that more than fifty per cent have disabilities of the mind or spirit which need treatment as well as those of the body. So I consider one of the important advances in the future of the teaching of medicine is towards the examination of the mind and its relation to the individual's daily life. Far too long has the teaching of this branch of medicine been left to the psychiatrist in the hospitals for mental diseases. It can, and must be taught as an integral part, and not as a specialty, of internal medicine.

Furthermore the whole relationship of industry to disability will be taught in time to the student. At the least, he must now realize that man is a reasoning animal and not merely an anatomical aggregation. Also he must realize that symptoms, if anything, are more important than signs; that they are the indicators to assess the degree of disability and can in most instances be reduced to a definite functional explanation.

While prevention is most effective in the parasitic and nutritional diseases, progress has gone much beyond these, and prevention has become of great practical value in various other lines such as cardiac, occupational, orthopoedic, and functional. While this is generally recognized there are many teachers who have a feeling that the field of prevention is still a restricted one, and of but collateral interest of value in practice. If those who are somewhat skeptical concerning the present importance and effectiveness of preventive measures examine into the matter, they will see that much of what is done in treatment, with the traditional subconscious or conscious feeling in which it is curative, is really preventive treatment.

It is highly desirable that there be a much more conscious and general effort on the part of many teachers to familiarize themselves with the preventive aspects of their subjects so far as they are suited to practice, and it is equally desirable that there be given to these matters, in teaching in all departments a degree of emphasis that is comparable to that given always to curative treatment. There will not be the impression that prevention constitutes a live daily responsibility of the practitioner until this is done, especially in all clinical departments and most particularly in general medicine.

For centuries there has been a sharp demarcation between the teaching of medicine and of surgery. To my mind the only difference is one of therapeutics. Otherwise they are essentially the same. Unfortunately some occult and unexplainable difference is conveyed to the mind of the student. I believe that in the undergraduate course the teaching of medicine and surgery should be taught as one subject in so far as etiology, pathology, diagnosis, and prognosis are concerned. This may be done by our teaching staffs being combined to accomplish the purpose. The therapeutic aspect of the disease is one of individual determination as to what is best to be done. The determining factor should be the patient under discussion at the moment, and not a "rule of thumb" procedure, oft-times determined by the chance vacancy of beds, the idiosyncrasies of the admitting officer or the fatuous adoration of some domineering relative or friend for a particular medical practitioner. It is on such chances that our teaching of rational treatment rests to-day.

Much thought is being given at the present time to the economic aspects of medicine, not only the economic status of the physician but also that of the patient. The rapid increase in our knowledge and the use of special diagnostic and therapeutic measures have brought about in the last generation proportionate specialization. This has been in conformity with developments in other professions. As a consequence the individual who is sick has been compelled frequently to seek advice from different specialists. In order that this advice might be more easily available, not only as far as the patient but also as far as the specialist was concerned, there arose the system of group practice. Such a system has had advantages. It has not only been economical in the way of overhead charges on the part of those physicians who have combined together, but it has also made possible an improved diagnostic and therapeutic practice. There are, however, certain deficiencies in the method, the principal being the fact that many people who are ill are not definite problems from either the diagnostic or the therapeutic point of view. In fact they might be said not to be physically ill at all but to require guidance in health problems of a spiritual as well as of a physical character. This can probably be given best by their personal medical attendant,—a man who knows them and their condition through all the vicissitudes of life. I do not mean at the moment to glorify the so-called family physician or general practitioner beyond his desserts, but I do not think anyone will deny that he filled, and should still fill, a position which is being left vacant.

Another disadvantage of the group system is the tendency for each member to be a specialist, and although this has its virtues still in the end the sick man must be viewed as a whole and not in segments.

There doesn't seem any doubt that the group system of the practice of medicine is here to stay either in its present form or under progressive modifications. However, it does raise an important question as to whether it should be controlled and expanded so as to fit in eventually with the trend of public opinion towards State medicine. If State medicine should become an accomplished fact not only must provision be made educationally for the perpetuation of the general practitioner but also for the specialist. This applies to the specialist in our present day accepted divisions and also for the specialist in such subjects as may be developed in the future. It is the production of this group of medical men and their control and certification that appears to me to be one of the most urgent needs in the future of medical education. As I stated in my address two years ago, it is not in the realm of an undergraduate medical school to produce graduates with an ordinary pass degree fully qualified in all the special branches of diagnosis and therapy. We can but give him the basis upon which to develop, if he so desires, the more complicated and erudite methods of specialization. He should recognize his limitations and be knowledgable enough to detect when the diseased condition has passed, or better, may

be passing, beyond his control. Under such circumstances it is necessary that the medical profession should see to it that this man has an adequate supply of specialists to whom he may appeal when necessary. I think one of the shortcomings in the medical practice of the day is the tardiness of the general practitioner to take advantage of specialized knowledge, so that frequently the patient quite independently seeks the advice of a specialist either locally or further afield. It may be that such special knowledge is not always locally available; but, with proper organization this could not and should not be the case. On the other hand, it is so easy these days for a man to pose as a specialist. He may go to some distant city and take a perfunctory course in some special line, and return posing as a specialist. Our medical educational facilities must be enlarged in order that proper post-graduate study, not of a few months' duration but probably of several years, may be available, and at the end of such proper preparation the candidate to such an exalted position should be required to pass an adequate test to confirm his knowledge. This has been done with great success in Great Britain by the high standards maintained in the colleges of surgery and medicine. The Fellowships in these colleges stamp a man as having attained a high degree of knowledge in whatever specialty he may have selected. The placing of a hallmark upon an individual that he is a specialist in any particular branch of medicine without at the same time demanding adequate proof of such, is a most pernicious system. I look forward to the day when no man in Canada may pose as a specialist in any branch of his profession without having devoted over and above his ordinary medical requirements a number of years of intensive study in post graduate schools of our own control. They should be regulated as we at present regulate the minimum requirements of our undergraduate medical course. This higher degree will be an insignia denoting the possession of a high standard of knowledge in the line of endeavour which the possessor has selected to follow.

I also believe that in the future, specialization in medicine and surgery will tend to disappear and will become more and more regional as it has in the past. It is quite easy to cite examples in what has already occurred to indicate what the future will probably hold. The ophthalmologist not only treats all surgical but also medical diseases of the eye; similarly the oto-laryngologist in his particular region, while the orthopœdist does not confine all his therapeutic measures to surgical interference. The latest addition to the rank of specialties in its complete form is that of the neurologist who not only diagnoses the case but also treats it to a conclusion whether by surgery or other means. The list may be added to by including the urologist, the gynaecologist, etcetera, etcetera. I believe the time will come, and that shortly, when all specialists will be trained in the so-called medical and surgical branches of their profession. For example, that the gastro-enterologist will not only diagnose and treat medically all diseases of the gastro-intestinal tract but will also pursue his regional therapy in surgery as well. Similarly, diseases of the lungs will cease to be handled by two separate sections of the medical profession but will fall under the control of the pulmonary specialist who will not only treat the chronic diseases but also the acute diseases by both medical and surgical means.

And now a few words concerning the under-graduate: The faults of his teaching may be crystallized into two phrases: he is taught too much and he is taught too little. Ill-considered and arm-chair criticism of present-day medical teaching has produced this chaotic condition. I suppose there has been no more criticized body of the profession in the last few years than the teachers in our medical schools. It has developed into a new sport—in journals, in associations, in congresses, in conferences such as this, in hospital staff rooms over the post-prandial pipe, the "straff" goes on. But, gentlemen, medical teachers are like other men. They are conscientious, self-sacrificing, and try to do their best, which I think, taking it all and all, is pretty good.

But let us come back to the under-graduate. He is supposed to be turned out a paragon of all virtues and knowledge; to be a skilled surgeon, ophthalmologist, laboratory expert, pathologist, obstetrician, general practitioner, and man of the world. In fact, a sage with a young body. Mephisto could not do it with Faust! Gentlemen, it just can't be done!

I believe the trend in the future will be towards simplification. Fewer subjects, fewer specialties as such, but broader and more fundamental conceptions of the few will be demanded. Seven subjects should be all-embracing, namely, anatomy, physiology, biochemistry and pharmacology, pathology, therapeutics and surgery, obstetrics and, finally, medicine. If he knows these completely and comprehensively he will know more than any one of us knows now, or ever has known. If he can leave us with this learning, we should feel we have done a rather decent job.

So I close with the words of John Stuart Mill as to the proper business of a university, " to seek for truth on all and demand to know all the difficulties in order that we may be better qualified to find and recognize the most satisfactory mode of solving them."

The Chairman: I will now ask Dr. J. S. McEachern to continue the discussion on this subject.

Dr. J. S. McEachern (Calgary): Mr. Chairman and gentlemen, when I received the invitation of the secretary to discuss the question of medical education I was at a loss to decide why that invitation had come to me, who have had no experience in the teaching of medical students. I took courage, however, when I remembered the well-recognized fact that if you want to learn anything about how to rear children you do not go to parents, who have reared them, you get the last word from the bachelor or the spinster.

However, we must recognize that the men who sent out these invitations were in deadly earnest.

The older brothers of the medical family, who have remained at home in order to help instruct the younger members, have in effect sent this message, " We want you, as one of the brothers who have wandered away from home, to come back and tell us frankly what the faults in the system of our rearing were that caused you to go wrong." I came with that message in mind. When I arrived I found that some of our old friends and neighbours—the press—were present. Their presence, I fear, is going to cramp my style.: There are some things, which one cannot discuss with absolute frankness lest one be misunderstood by those who are outside of the family. There are, however, some points which we can discuss openly.

Whether we look at an industrial concern or an educational system, there are inevitably two points of view. On the one hand there is the outlook of the leader; on the other that of the rank and file of the workers. I will endeavour to present the view-point of the man in the ranks.

Some of my hearers may say that I present a distorted view. If what I have to say will arouse discussion of our difficulties by the leaders, who are most competent to deal with them, the time will not have been misspent.

In approaching the subject may I use a simple illustration? In the early days of the " wild and woolly west " we had a class of men who were known as " Remittance men." They were sent from Great Britain with a physical equipment of money, guns for fighting Indians, clothing wholly unsuitable for the country, English saddles, which were utterly useless when he attempted to ride the hurricane deck of a western cayuse. The wiser of them soon decided to discard the unsuitable part of the equipment.

They came with something more important—a spiritual equipment, which led them to become either " Ranchers " or " Rawnchers." If he came with the mental outlook of the former, he accommodated himself to the changed environ-

ment and became a powerful force in building up the country. If his spiritual equipment was of the latter type, he never got much nearer to the truth with regard to the problem of making himself a good citizen. In each case it was not the physical equipment so much as the mental outlook, which was the determining factor in his success or his failure.

The graduate in medicine has much the same problems to face. Certain impedimenta, which are unsuitable for the new environment of actual practice, have to be discarded. His mental attitude toward the work of his profession and life in general will, however, be the determining factor in his success or failure.

Before we go further it may be well to consider what education is. It is necessary to refer to this question only briefly. Dr. Meakins, in his most admirable paper, has dealt with it. After all, education whether it be medical or otherwise, is simply the process of training a man so that he may be able to search out truth.

The component parts of any "system" of education will be, roughly speaking, on the one hand the strictly physical, as represented by buildings, laboratory equipment, etcetera; on the other hand there will be the intangible spiritual equipment embodied in the personnel of the instructors. Lastly and perhaps as important as any, the raw material represented by the students.

We hear much criticism of our system of medical education. This criticism comes from the medical men themselves, verbally and in the columns of the medical journals. It comes very freely from the lay public and the lay press. One is struck by the superficial character of most of the criticism—the failure in most cases to go to the root of the evils. Even more, one is struck by the poverty of constructive criticism, the pitiably few suggestions for the overcoming of the ills.

It seems to me that most of the evils in our system are traceable to, at most, two fundamental difficulties.

If we look at the equipment in our educational system and attempt to analyze all the constituents, we may perhaps arrive more accurately at the source of the trouble.

Everyone will agree that there has never been a time in the history of medical education when the physical equipment, in the way of buildings, laboratories, and hospital facilities, has been so good as it is at the present.

With regard to the teaching personnel, speaking from the standpoint of the man in the ranks, I cannot agree with Dr. Meakins' statement that the teachers have been criticized. After discussing this particular phase with many practising physicians, old and young, I believe that there is a feeling among them that at the present time there is better teaching of the individual subjects than there has ever been in the past. I think that there is almost unanimous agreement on that point.

With regard to the spirit which animates these teachers, no stronger demonstration can be asked for than what we have seen in the past three years. These men have not only devoted themselves whole-heartedly and enthusiastically to their work in the schools, but at great inconvenience and with a good deal of self-sacrifice they have travelled the length and breadth of this country giving post-graduate lectures and clinics. They have done all that was required of them as teachers in their schools. In addition they have voluntarily travelled over the country doing what the manufacturers would term "servicing."

The last item to be considered in our system of medical education is the raw material—the candidates for a medical degree.

Just as the "Remittance man" came to the West in the early days with an outlook on life which directed him along the path of useful endeavour, or with an outlook which resulted in his becoming a useless drifter, so the raw material

comes into our schools. One group comes with a mental attitude which impels them to search for truth. Another group, with an indifferent outlook, drift with the tide and find the truth only by accident.

In an industrial system—let us say the manufacture of automobiles—the organization reserves for itself the right, not merely to select its raw material, but from time to time to eliminate that material right up to the moment when it would otherwise go into the completed automobile: That is a point which we might well bear in mind with regard to our system of medical education.

Let us now examine the material after it has become, so far as our medical educational system is concerned, the finished product.

If we look over the Medical Profession as a whole we find that the overwhelming majority are earnest in their endeavour to search for the truth. They spend their lives carrying out the principles which their teachers have carefully inculcated during the undergraduate period of training. We need not consider these men further. If they comprised the whole of the profession but little criticism could be levelled at the system which produced them.

There is, however, another type. There is a class of men, who have not at the outset realized that the practice of medicine will lead them along a hard road, " a road that can only be trod by the foot of a man." They are always looking for the easy by-paths that almost invariably lead them into a cul-de-sac. It is due to the behaviour of that type of man that unfavourable criticism is brought down upon the Medical Profession as a whole. One of the great problems that our system of education has to deal with is to eliminate that type.

Upon superficial examination these men seem to be all of one type. There are really two subdivisions of the type. On the one hand, there is the man who will not work. He has never learned to work. He has not inherited or developed in the early days of his life a love of work for its own sake. What are you going to do with him? Some one says, " Teach him how to work."

This reminds me of a little incident. A parson was engaged in missionary work in the east end of London. One Sunday morning while walking along the docks he came across a couple of navvies who were repairing the road. One of them was pounding a bar with a hammer. He looked up and while doing so he accidentally struck himself on the thumb with the hammer. Thereupon he broke out into a volley of profanity and obscenity that can only be attained by the East London gentleman. The clergyman listened until he was through and then said to him, " My dear man, where do you learn such horrible language?" The navvy looked up with a smile and replied, " Lor luv yer Govenor, yer cawnt learn it; it's a bloomin gift."

It should be recognized that there is the sort of man who cannot be taught to work. If that discovery be made, and it should be made in the first or the second year of his undergraduate career, he should be eliminated.

Let us now consider the second subdivision of the type under consideration.

There is the man who is willing to work but who at the same time has a tendency to follow the easy by-paths. He has failed to correlate the teaching which he received. He is dazzled by the glamour of the specialties. At the same time he fails to realize that the foundation of each of the specialties is a sound knowledge of internal medicine. One of the greatest handicaps to-day for some of our so-called specialists is the fact that they have failed to realize that they must be first, last, and always, physicians.

What is the solution? How is this type of man to be guided aright? It seems to me that Dr. Meakins in his paper has proposed it. The instructors in medicine and in surgery must impress upon the student that they both stand on common ground—the field of physical diagnosis. If the graduate is sent out fully seized of the importance of diagnosis he will have a right start.

I cannot close without referring to a certain class of men of the right material and with the right outlook, who are by stress of circumstances prevented from gaining access to the medical profession. The amazing advances in medicine in the last thirty years have necessitated a tremendous overloading of the curriculum. This has resulted in the extension of the medical course; first, from four to five years, then from five to six years. If the same policy is to be applied in future, it must in time lead to still further lengthening of the course.

At the present time the young man without money but with the proper spirit for the practice of medicine is debarred from the profession. He cannot earn sufficient money to pay for the expense of the course if he hopes to graduate sufficiently early in life.

Is it possible to shorten the course and at the same time maintain a standard high enough for the general practitioner? If so, we would be able to recruit a desirable class of men, who are now debarred by financial disability alone.

The establishment two days ago of the Royal College of Physicians and Surgeons of Canada has some bearing on this question.

The ambitious progressive man, who qualifies as a general practitioner, has an incentive to increase his knowledge in some special branch with the assurance that if he can qualify the college will place its hallmark of approval upon him. In time the public will recognize that the only man who has the right to pose as a specialist, is he who bears that hall-mark or its equivalent. The family physician will then not be required by the public to be possessed of skill in special lines.

I am quite aware that there are very many difficulties in the way if an attempt were made to carry out this suggestion. If it is possible to do so, I feel sure that the general profession of medicine would be enriched by the entrance into it of men who are now debarred for financial reasons. The specialties would be enriched by the entrance of men who have made general practice a stepping stone to reach them. Under the new conditions these men could not, as so many now do, simply label themselves specialists.

The attainment of Fellowship in the Canadian college would be a guarantee that they had done special work in order to qualify.

With regard to the teaching of cultural subjects on the medical course, I agree with what Dr. Meakins has just said.

Dr. Primrose has expressed the fear that the elimination of unsuitable men is impracticable.

If it is desirable that this should be done, I am sure that it can be done. Some form of agreement, to which the student or his guardian or both must subscribe on his admission could give the authorities of the university power to eliminate him if, in their opinion, he proves unsuitable.

DISCUSSION

The Chairman: After listening to these very instructive and practical papers, I am sure there will be a desire on the part of many to enter into discussion. I must remind you gentlemen, however, of one important rule of procedure: five minutes is the outside limit for any one wishing to discuss any points brought up in this morning's papers.

Dr. A. Primrose (Toronto): I think it will be generally conceded that Dr. Meakins, as the recently appointed President of the Royal College of Physicians and Surgeons, in his first utterance since his appointment to that august body, has given us an excellent paper and one which gives us food for thought. He is to be congratulated upon it. And no less valuable a contribution, though from a quite different standpoint, did we have from Dr. McEach-

ern—an address which we as teachers should take very seriously to heart, and those of us who have to do with medical curricula should consider well. These two papers are eminently practical: Dr. Meakins' is broad, and so is Dr. McEachern's.

It is the irony of fate that Dr. Meakins, as head of the Royal College, should have to put the stamp of approval on specialism. This, of course, is not inconsistent with his paper, for he has told us that the specialist who is best as such is the man who has had a thorough education in general medicine as well as in the specialty which he wishes to practise. That is a sound argument; he has stressed it, and I think we are all agreed that the man who goes into a specialty without a thorough knowledge of internal medicine is a menace to the public. I quite agree with that point of view, and I am sure that those of us who are teachers will all endorse it.

Some of you may be surprised to learn that men entering the medical profession to-day really start out with the idea of taking up some special line: they have a specialty in view. I am not sure whether Dr. Harrison is here, but he could give you some statistics on that point. It is quite remarkable what a large percentage of the entering class in one of our universities have determined to practise a specialty when they take up medicine. That is an entirely wrong beginning for any student. I do not believe it is possible for any young man, until he has proceeded with his course, to determine what he is fit for. Specialism is a dangerous thing.

Some of you who were present at the meeting in Montreal a short time ago will remember a story told by one of the professors. He referred to an incident which had occurred when he was a student in Johns Hopkins University. A certain patient was declared, after examination by a specialist, to be suffering from tuberculosis, and a few days afterwards, going to a specialist on syphilis, very much the same process was gone through as before, and the case was said to be one of syphilis. Dr. Osler was then in charge of internal medicine in Johns Hopkins. He saw the man sitting in a far corner and he said, "Boys, here's a case of leprosy—the first I have seen since coming to Johns Hopkins." That is an illustration of what specialism may result in, more particularly with specialists who have not had a general education.

Dr. McEachern referred to the elimination of students. We find that an exceedingly difficult matter in Toronto, although we do our level best at the end of the first year. First of all, when they are admitted, we sometimes advise men not to come in. They must come in, of course, with full credentials; no credits are allowed. When a man does come in he goes on with his first year, and we do our very best, if he has made a poor showing, to persuade him to take some other course. If we refuse to permit any student to repeat his year, what happens? Some persistent individual, with the backing of his parents, will come and insist upon having another chance. Sitting around a table with a number of legal lights in Toronto, we have found that legally we cannot throw that man out. I do not know what the experience is at McGill, but that is the situation in Toronto. It is not because it is a provincial university; that is the law. Legally we are unable to reject a man who persists in his claim to the right to try further examinations.

I might elaborate the principle. These legal lights tell us you cannot throw a man out of a private club even, without running the risk of a law suit, because in doing so you defame the man's character.

I should like to know what has been the experience of the other universities in that regard. In Toronto we do everything we can to dissuade impossible students from continuing; we write the strongest letters to parents and guardians, pointing out the unfitness of such men to study medicine, and advising their withdrawal. Of course, we may make a mistake in giving such advice, but I

know of no such instance in Toronto. Dr. C. H. Mayo was once told that he was unfit to study medicine—and Dr. Mayo has made a success. So it is just possible for one to be mistaken.

Dr. Meakins suggested that it took some fifteen or twenty years for any new idea to obtain recognition in the profession as a whole, or—if I understood him rightly—in the teaching of medicine. That does not apply nowadays to the graduate, who is capable of receiving any new discovery. I often think of Lister's experience when he gave his wonderful discovery to the world: it was a quarter of a century before he could persuade his colleagues that he had found anything of value. But to-day, by reason of the education which our men are given in laboratory and in clinic, our graduates are ready to accept a new discovery, to prove its value, and to use it. Take insulin for example: it was only within a few months of its discovery that it was utilized by the general profession. It was checked up in the laboratory and it became known; it was proved to be of value and it was used immediately.

Dr. Austin (Kingston): I have been associated with the teaching of medicine as long as I can remember, and I am still at it; and I find two cardinal difficulties in the teaching of surgery. The first difficulty lies, not in the teaching of anatomy, which after all is the fundamental subject in surgery, but the difficulty which the student has in retaining even the most elementary facts. We who have done anatomy—and I am sure Dr. Primrose will agree with me in this—know that we had to do a vast amount of work before we really began to know anything about it, and did not know much until we had taught it. I do not care whether it is in my own university or any other, I find that many students, by the time they have reached their sixth year, are still weak in anatomy. The explanation is, I think, that the pressure of the curriculum has driven anatomy into the position of an almost secondary subject. That is my first difficulty. The second one is, I believe, greater still, and that is the introduction of the student to the clinical case as part of the course, at the beginning of the fourth year. I remember myself, when I had done anatomy and physiology and was suddenly thrust into the wards of a big hospital, without any instruction except what a house physician could give me, I was completely lost. I find this an ever-recurring problem each year—how to enable the fourth year man to get a start. It is important to demonstrate to the students that the anatomy which they regard as such a grind is really an absolutely essential part of their training.

Dr. A. J. MacKenzie (Toronto): The subject is of the greatest interest to us, whether to graduates or to those of us who have to do with teaching. There is just one phase of it which I wish to touch upon. There can be no question, to those of us who have been in touch with the progress of things in the last decade especially, that the trend of medical education is towards the making of scientists. The brilliant advances that have been made in medical science, and the advance as well in the methods of teaching scientific subjects, have enlarged the minds of medical students. There is no question about that: they do acquire an enormous knowledge of these sciences.

Perhaps the results that Dr. Austin secures in anatomy are not as satisfactory as when some of us were students, for in those days we had to grind constantly at the subject for two years, and almost in spite of ourselves some of it stuck. It might possibly have been that we had an outstanding teacher in our day, but I fancy there are men of the same calibre in the universities to-day.

The student nowadays is impressed, and necessarily, I think, impressed with the scientific attitude towards disease. Symptoms and derangement of functions are, I believe, more important to the doctor than is the basic physiological cause of the disease. When I say it is more important, I mean for prac-

tical work. Perhaps 75 or 80 per cent—I cannot say exactly—of the work has to be done by the doctor; and what he has to do is to treat the condition which he finds. He has to have some practical knowledge of advanced discoveries; and in some cases—for instance, in regard to insulin and a few advances of that kind—he has to study the development from his basic science up to his treatment. When it comes to the treatment of some other things, however, the connection is not so plain.

The weakness which I find in our medical students lies in the want of practical knowledge. They meet conditions with which, from the scientific standpoint, they are perfectly familiar; but they are completely stumped practically, because they have never done, nor seen anything done, in a practical way. The practical work is not done very much in the hospitals except by the nurses. How is that condition going to be met? I have had a brilliant student come up in his examination, and, having suggested that for some types of nervous excitement, the hot bath and alcohol treatment would be advantageous, I asked that student what the temperature of the bath should be and he replied, "160 degrees centigrade." Of course, that is due in part to excitement and the fear of the examiner. But the student should know these things. That has to be kept in mind constantly.

The only suggestion I have to offer is that our hospitals should do more in the way of accepting intern attendants, so that they might have continuous training. It may not be possible for every man to take an internship, and after all there are practical difficulties there. But while I admit the value and extraordinary interest of scientific subjects, I think we shall have to cut some of it off and give these men a chance to get some practical knowledge, so that when they come out they will know a little more than the mother of the child whom they are going to treat—at least, they will know as much, and will not be dangerous: they will know what temperature a bath should be, will be able to give a simple enema, and will give a hypodermic without fear of killing the patient. This may seem a small thing; but I can assure you, having met students, and having sized up their work after they have graduated, that from my observations it is of sufficient importance to make it worth while mentioning.

Dr. H. McPhedran (Toronto): There are one or two points I should like to comment upon. First of all, I wish to congratulate Dr. Meakins and Dr. McEachern on their very able addresses.

Dr. Meakins referred to one thing with which, probably unlike most of you, I have had some experience, and that is working in a clinic. It has, to my mind, a great number of advantages. For example, you get together a group of men who pool their ideas, and on the whole, when it comes to a diagnosis, I think the patient stands to gain. On the other hand, it has its disadvantages. There is a tendency to lose sight of the patient—that is to say, as an individual; no one person seems to be responsible for him, and therefore one cannot get from that patient the facts that are fundamental in the treatment of his illness. It has this further disadvantage—and this, I think, applies without exception to all the clinics, or the larger clinics—that the financial backbone of the institution is the surgery which it gets; and therefore the moment a patient crosses the door he has a premium on his head for a surgical operation. That is wrong; it is wrong from the doctor's standpoint, and is so often fatal from the patient's.

However, there are virtues in the group system of practising medicine, and I am inclined to think, with Dr. Meakins, that that form of practising medicine will obtain to a greater extent in the future than it has done in the past. Medicine, in its practice, has become so complex that I believe, to give the patient a square deal, some working together of doctors will have to be the rule in the

future. It would be of great benefit to the young man; it would be highly advantageous to any man if, when he graduated, he could associate himself with men of experience. I know that you have all had practically the same experience as I had at the outset; and I am sure that those of you who started in smaller offices particularly must have felt your utter incapacity, in the earlier stages, in dealing with a great many things that came under your supervision—things that would have been made clear, and in coping with which you would have been materially assisted, had you been associated with older men, probably in much the same way as in the Old Country, where a young man is taken into partnership with an older practitioner, grows up in that partnership, and eventually himself becomes senior in the establishment.

One other point has been referred to, and that is the training of specialists. I have had some experience, as all teachers have had, with young men coming into the university with specialism as their objective. Most of those I came across were going to be specialists in surgery. I think it is a tragedy. You see them at the present time eager to take up nose and throat work. Why? There is only one reason: it is easy work, and the financial returns are good. Men will not go into the outlying districts to practise where there is hard work, with a small return. Something will have to be done about it. What plan can be devised to induce our young men to go into outlying districts, where human life is just as precious as it is in the city, and do pioneer work, I do not know. But something will have to be done. Probably it will eventuate in some scheme such as our friends out west have adopted—some system of state control in the practise of medicine. But in the training of specialists one fact will have to be emphasized more than it is at present, namely, that the foundation of any specialty is general knowledge. While I agree with what Dr. Meakins has said about years of post-graduate work, I hope the fact will not be lost sight of, that the best foundation any practitioner can have for any specialty is a good training in general practice.

One word more. I do not think the universities are exploiting their opportunities to the full. A man once graduates from the university and goes into practice, and he loses touch with the institution. What effort are our universities making to-day, apart from the splendid efforts of the Canadian Medical Association and the provincial associations? They are doing excellent work. But what efforts are the universities themselves making to coax, and perhaps to compel in some way, practitioners to keep in touch with them periodically? Men have been in practiee ten, fifteen and twenty years and have never been back in order to catch up with the recent advances in medical science. Something should be done in this regard. These men should be persuaded, and perhaps compelled, to go back, say, every five years, and some young graduate could carry on the practitioner's work while he was refreshing and increasing his knowledge.

Dr. C. F. Martin (Montreal): One hears a good deal about systems of medical education, but this, I think, needs to be said: No matter what your system of education may be, no matter how meticulous one may be in the arrangement of courses and in the allotment of work, unless you have a good teacher you will fail in your essential object. One of the greatest defects in our system in this country—and it is even more marked to the south of us—is the fact that we are not sufficiently careful in the selection of teachers who will present their subjects in the proper way to the student. The worst student in a class may be made interested, and may develop into a good man, if he has the proper instruction, the proper guidance, and the proper general education.

We can think of great teachers who in the past have led in our various schools, and we can affirm with a confidence that their students have gone out well prepared in their subjects, not because of any peculiar merit in the system which they followed, but because the teaehers were inspiring.

So that when you are talking about system of education the fundamental thing is the selection of the teacher and if our medical schools are at fault, the fault lies primarily in the fact that, probably, they are not fortunate enough to have great teachers in all their departments.

Another thought comes to my mind, and it is one which has been referred to already: I mean the teaching of essentials. Of course, we all try to teach too much, and one of the reasons is that we do not realize—that is to say, we are not good enough teachers to realize—that what we must stress are the essentials. We can leave out a great deal, allowing for the subsequent filling in, if you like, of minor details. But if we presented the essentials to our students they would certainly come to graduation with a very much better general knowledge.

In the selection of students we have the same difficulty as every other university, from the number of applications. Last year we had seven hundred and fifty applying for one hundred places, and the difficulty of selection, even in what seems a very large number to choose from, left us with quite a number of instances in which our judgment afterwards and their credentials combined showed us the error of our ways. It is not an easy matter to select students, with confidence that they will graduate successfully.

As to the elimination of students, that is a comparatively easy matter, and I can assure Dr. Primrose that we have experienced no difficulty in that regard. Indeed, I had not realized that there was any legal obstacle in the way; nor do we intend to pay any attention to such a consideration.

To sum up, I repeat that the system of education depends, first and foremost, on the teachers in our medical schools. With such teachers, the system will occupy a secondary position; because great teachers will know, each in his own way, without any standardization, what the student needs, and how best to impart instruction to him.

Dr. E. S. Ryerson (Toronto): With reference to the point raised by Dr. McEachern regarding what might be termed the spiritual qualities making for success in the man who enters practice, I might mention a survey which was made among the practititioners of Canada with a view to ascertaining the reasons which the individuals canvassed assigned to their success. A series of questionnaires were sent out to a large group of successful practitioners asking them why they were successful in practice. The answers were analysed, and it was found, in the majority of cases, that personality and character ranked first among the reasons, while fourth in the list came knowledge. This would seem to strengthen the point Dr. McEachren made.

Now we may all readily recognize these as extremely important factors from the point of view of the individual practitioner himself. But from the standpoint of those who are interested in medical education and in students, the question at once presents itself: how are you going to determine whether a man is of admirable character or whether he has personality? What is personality? Can anyone define it? Some of the universities are trying to have this question answered by means of personal interviews with students, but they can reach no conclusion that will afford any standard of judgment. One man can define personality in no other terms than to suggest that personality is "It." And that is about all that any of us can say. You cannot possibly say, in a student of 19 or 20, whether he will develop such a character as will make him a success in practice when he graduates some years later.

Our system of examinations is nothing but a test of proficiency so far as knowledge is concerned; but it does not offer any means of ascertaining the facts of character and the indefinable thing called personality. Nor is there any way of finding out. Some years ago the professor of psychology in Toronto University kept records, over a period of two years, of students who had

matriculation standing, and he found absolutely no relation between the matriculation standing of a man and the standing he took during the medical course. A man may do extraordinarily well on matriculation and be a poor medical student, or vice versa. On the other hand, he found a much closer relation between the standing a man took in the pre-medical sciences—physics, chemistry and biology—and the standing he took in his medical course; while the closest relation appeared between the ability he showed in biology and the record he made in his medical course.

When a student is told at the end of his first year that he does not seem to have the ability to go on with his medical course, he is apt to inform us that at high school he took honours in this, that, and the other subject, and high school teachers will say he was the most brilliant student they had. That may be so; but we have discovered by investigation that, in the majority of cases, the mere fact that a student did well in high school is not necessarily an index to what he will accomplish in his medical course.

A psychologist and doctor at George Washington University has devised an interesting test, which consists in placing before the student a large diagram displaying about twenty-five of the different main structures of the body, which are named, with corresponding numbers at the side. The student is allowed to study this for a while, and then the diagram is again set before him, but without the numbers, which he has to fill in in their proper places. In addition to that, he is given a general description of the physiological connection between various structures, and he is afterwards tested to ascertain how far he has retained this information. The test is a fairly lengthy one, and was carried out last year and the year before in about twenty different American universities. On a comparison of its results with the results of pre-medical examinations in physics, chemistry and biology, it was found that whereas 22 per cent of the successful students in the latter examinations proved successful in their medical course, 68 per cent of those who were able to pass this test were also successful in the other.

One point of interest which appealed to me in Dr. Meakins' paper, and in regard to which I agree with him almost entirely, is with reference to what he said in the matter of diagnosis and prognosis. It seems to me that the student, as he comes into contact with the patient in his later years, does not get towards the patient that attitude in which he realizes that the practice of medicine is an intensely personal affair. I do not think this fact could be better illustrated than it is in a little article, "The Care of the Patient," which Dr. Peabody published two or three years ago and which we have been recommending to every student. The personal side of the relationship between practitioner and patient is also to some extent obscured—at least it is not fully realized—when the student comes into the wards for clinical instruction. He gets the idea that he is learning medicine, he is learning surgery, he is learning a particular subject, and he is not gaining experience so far as the patient is concerned as an individual.

Dr. T. Parizeau (Montreal): I was greatly impressed by Dr. Meakins' paper, and I may tell him that as a matter of fact we have been trying to put into practice some of the ideas which he advances. Dr. McEachern has also made some points of vital interest. As regards the selection of students, we have been exercising the strictest care, and in the first and second year we have put back as many as from 10 to 15 per cent of our students, realizing that they have not the aptitude for medicine.

The statement has been made here that students are graduated into practice without a practical knowledge of medicine. They are trained scientifically, but when they go into practice on their own responsibility they show a want of practical ideas. This fact has caused us some concern. Under our

aegis there are some hospitals that need internes, and as we have increased our course from five to six years there is a shortage of graduates or internes. But the disease provided its own remedy, and we made the whole graduate class internes. In their first year our students go through an interneship. They go through several wards; they have a period of interne medicine and a period of surgery. This has been the practice now for three years, and the results are gratifying. Of course, if the number of our graduates increases we shall have too many internes, and we shall have to sacrifice a second class which we created, that is to say, the graduate interne.

Dr. G. A. Ramsay (London, Ont.): One question which I should like to hear discussed, both from the standpoint of the university and from the standpoint of the practice, and that is the value and extent of so called cultural subjects in the medical curriculum.

Dr. J. C. Simpson (Montreal): I shall take up just a minute or two to discuss some points brought out by Dr. McEachern. Reference has been made to character, and no one can have anything to do with medical education without realizing that character is, of course, essential; it is far more essential than is the knowledge of pre-medical subjects.

One point I would stress is this: many students have fallen down, not because they do not work but because they do not know how to work. It surprises any one who has anything to do with the teaching of students how many men can go through high school—perhaps three or four years—without learning how to work. It seems that, in the early years of the medical course, one of the things we have to put more effort into is training the student in proper methods of study—in other words, how to work.

One other point I wish to refer to. Dr. McEachern spoke of the elimination of material. Sometimes we are inclined to retain a traditional method because it is traditional. But to-day we have to eliminate subjects that are no longer necessary and come down to essentials; we have to remember that we are not turning out a finished product. When you buy an automobile made in the most efficient factory you are warned to drive slowly the first five hundred miles. Well, we cannot expect to turn out, at the end of five or six years, a student who will be then and there a finished practitioner; we can however turn out a graduate capable of development. And that seems to be lost sight of sometimes.

Dr. E. J. Boardman (Winnipeg): I have just one remark to make, and that is with reference to the statement that many doctors do not go to outlying districts. The reason for that has already been explained. Students who are internes in hospitals get their training in institutions that are highly equipped, and these men are trained for work under certain conditions; and they do not go to outlying areas for the reason that work in those areas, without hospitals and nurses, without charts, without accessories, without the various facilities to which they have been accustomed, is a job for which they are not trained.

Dr. J. S. Poole, (Neepawa, Ont.): For Dr. Austin's benefit I might cite an instance from my own experience. I remember when I went up for my anatomy examination. Another student and I were the last for the day, and I felt not a little nervous over the ordeal. But my comrade reassured me: he said, "We may not know much, but we know a great deal more than the examiners anyway." That may cheer Dr. Austin's heart.

In my opinion, students would be better trained if they were more under the care of general practitioners during their course than under the care of specialists. If there were more general practitioners in the hospitals they would train the student, the coming physician, more in the ways of the general practitioner, and he would have more confidence in himself when away from the X-ray and the laboratory.

Dr. D. S. Johnstone (Regina): I sometimes wonder whether the question is ever asked medical men, why they took up medicine. I know that in our part of the Dominion, where we have no university teaching medicine, we have many practitioners who studied in Toronto, McGill and Queen's, and I find in many cases that, on leaving the collegiate institutes, they entered medicine because somebody else had done so. It seems to me that the elimination process should begin before they enter the university; some attempt should be made to discover, in the collegiate institute, just those who are likely to be adapted to the practice of medicine. If the universities had some means of contact with the collegiate institutes, the preliminary training schools, whereby a selective process could be arranged, we should be better off than we are now; and I submit that the proper time to eliminate students is not after they have entered medicine but before they begin at all.

Dr. J. A. Amyot (Ottawa): I have often wondered why the French system has not been thought of more in our method of teaching. When a student enters the University of Paris they take care that he has a preliminary education before he starts. The first half of his very first day is spent in the hospital. He goes there about half-past eight in the morning and is there until eleven o'clock, going about with the interne and with some of the minor men in the hospital, and he has to do that all through his course: he spends the first half of the day going through the hospital. Might we not adopt some such system here, making every one of our medical students attend the outdoor clinic from his very first year?

There is another point which is lost sight of. You cannot make a complete man in a medical course. You teach him certain subjects, but he must perfect himself. Let me give one illustration. Suppose you teach a man all the principles that are involved in staining such a plain ordinary thing as a tubercle bacillus. You make him do it four or five times, and you have no time to do more. Then you send him out. The first time he has a case he thinks it may be tuberculosis. He has not found a tubercle bacillus but he cannot say it is not there. He begins to wonder to himself: "Did I fix that specimen? Did I stain it long enough? Are my stains right? Did I decolourize too much? His technique is not worth anything to him until he can say, "I know that stain is right; I know I have fixed it and stained it properly and have not decolourized it too much. The tubercle bacillus is not there." And the only way he can acquire that assurance is by practice.

I remember going once to a little town in Western Ontario and a practitioner asked me, "Why don't they teach this in the university?" I asked him, "Where were you when that was being taught?"

There are all these difficulties to consider; but to me the French method offers the one solution—training men right from the start. Let them hold the pus basin; let them hold the leg when it is being fixed up; they can very well do this. Let them look at the patient from the very start. In France they have the very best teachers they can get—they are well chosen. In the University of Paris the professor may have a squeaky voice; he may be old; but every one of his lectures is a masterpiece. The student may not attend the lecture, but the practical side of the work he must do—the hospital side—or they will not consider him at all.

The Chairman: One of the important points brought out in Dr. McEachern's address is that there are certain people who are bringing discredit upon the practice of medicine. We can, I think, classify these as knaves, fools and misfits. It is up to the individual schools to find some method that will eliminate them from graduation.

So far as the curriculum is concerned, I would say that the chief essential is that it be balanced. That means that the teachers have to be balanced in the presentation of the subjects, and that the students have to be balanced in their reception of the subjects. I would suggest that this is another matter for individual treatment by the schools. I think that there should be advisers to the students; a group of students being under a supervisor and not necessarily that the adviser be a member of the staff. Why not get the general practitioners in the cities to do that work? I am sure they would be glad to do it. Let them be the friend and adviser of respective groups of students.

Dr. Meakins: I wish to thank Dr. McEachern for his encouraging words. At times, like every other teacher, I am apt to feel disheartened, but what he has said this morning cheers me. Two and a half years ago I made a rather pointed indictment against the raw material sent us. You cannot make a silk purse out of a sow's ear; and my indictment then was against our method of primary education. From another angle we had it very well put to us last night. It is no part of the function of a medical school to teach a man cultural subjects, nor is it the function of the medical school to make a gentleman of him if he is not one when he comes to us. A man has learned to be a gentleman at his mother's knee, around the dinner table, and in the family circle. We can set high ideals before him, but if he cannot appreciate them we cannot help him.

The time devoted to medicine has been a subject of great controversy from time to time, and I am very glad to say that the time spent on medicine at McGill is now equal to that of all other specialties put together. When I say medicine I mean clinical medicine, internal medicine, pediatrics, dermatology and all other specialties so called.

It is not the function of the physiologist to teach pathological physiology; it is not the function of the anatomist to teach surgical anatomy. Applied physiology, applied biochemistry, applied anatomy must be taught by the physician and surgeon. It is not right to ask the anatomist to teach the student the surgical anatomy of a particular operation. As Professor Wallace, of the faculty of Edinburgh, once said, "Let the anatomist teach anatomy; I will teach surgical anatomy." And I doubt whether there has been a better surgical anatomist in the world.

There have been two enormous chasms in our method of teaching. The first, which I have indicated, is that between physiology, anatomy, biochemistry and the clinical subjects. The next is between diagnosis and therapeutics—so called surgical and medical diagnosis. For the life of me I cannot see the difference: the same things lead us to a common conclusion whether we are surgeon or physician. But the fact is that the distinction is made between surgical and medical diagnosis, so that frequently the student leaves us mystified. Shall I treat this case medically or surgically, he asks himself, when it is the same case. We must bridge the chasm between one way of treating a case and the other, depending upon whether the diagnosis is medical or surgical.

I fancy that from the first of November until the first of February I am consulted in a friendly way by fifty per cent of the graduating class as to what they should do in the way of interneship to fit them for their practice. I say to them, "What is your ideal?" It used to be, "I am going to be a surgeon, or an ophthalmologist, or an obstetrician". You would be surprised to know how many of the men who have come to me in the last few years say, "I want to be a general practitioner". I ask the student how long he is going to remain an interne and he says, perhaps, two years. "Very well", I say; "take one year in medicine, with such pediatrics as you can get, and another year in obstetrics." They want to know why, and I tell them that, going out as young men, they will have young people as patients, and they will have babies. I say, "If

you can keep the mother well, and the baby in good health, you need not worry about the old man. You must keep the household well. If you know your medicine and how to keep a well baby well, and can allow the woman to confine herself properly, you will get on."

Last year two men came to me; they had their towns picked out—nice "cushy towns, short of medical practitioners and with lots of money. Last June one of them came back asking for a recommendation. I said, "What for? I got you the job you wanted." Yes; but he had decided to give up general practice and go in for a specialty. And the other man decided to be a surgeon. They saw ready money and they gave up their ideal. Only last week two fine outstanding fellows came to me, saying they wanted to be general practitioners; they knew just where they would practice. My experience with the two the year before came back to me, so I advised them to practice right away. What the future of these two boys will be I do not know.

One of the speakers has referred to practical therapeutics. We are trying to teach practical therapeutics as best we can; but the student does not like to give an enema—the nurse or the orderly can do that. They consider it rather degrading, although we try to make them do it. But they will get out of it if they can; they contrive to be absent when the enema is to be given.

Dr. McPhedran was much more courageous than I was in regard to group clinics. I appreciate their value, but they must be controlled. There must be some control even if it is only public opinion: for we know the significance of that sign over the door, "When thou enterest here, prepare for an operation."

Dr. Ryerson has referred to the importance of mental development. Most of us can look back on our own lives and almost fix the moment when the cloud seemed to pass from our eyes and we beheld the future. In our primary education, as Professor Leacock says, students are not allowed independence; they must do the same thing over and over again. They do not learn how to acquire knowledge but how to store facts: and, in a mysterious way, the facts when they want them are not in the right pigeon hole. Education is not memory; learning is not memory; learning is a well cultivated field which in years to come is going to grow a bumper crop.

Dr. J. S. McEachern (Calgary): With regard to one or two questions that were asked: First, as to the point of view of the man in practice with regard to the teaching of cultural subjects in the medical course; the answer to that has just been given by Dr. Meakins. Personally, I think his opinion is shared in by a very large number of men.

I think that the point Dr. Martin brought up with regard to inspiration is a very important one; I think, at the same time, that the advanced idea that has been brought forward by Dr. Meakins will pretty well solve that—the advanced idea, which is, after all, perhaps but reverting to an old ideal—that the teaching of diagnostics is not the prerogative of only one specialist, but that it should be taken part in by men teaching any of the specialties. If the surgeon devotes the time in a clinic to elucidating what may seem to the student to be a medical point, the latter will at once realize that, after all, the surgeon must be equipped with a knowledge of what we call internal medicine before he can practice his specialty satisfactorily. I think the carrying out of that system of teaching would give the student a better perspective and send him out with the realization that, after all, it is medicine and not any special branch of the various therapeutic methods that is the important thing.

The Chairman: We will now pass to the next subject on the agenda.

This will not take very long as it is more in the way of presenting a report. We will then take up the report of the Resolutions Committee which will implement the results of the discussions that have been taking place.

I will now call upon Dr. C. F. Martin, of Montreal, to introduce the discussion.

Dr. Chas. F. Martin (Montreal): Mr. Chairman and gentlemen, the subject of periodic health examinations is so familiar to all of you that my words need not be many. While, however, the subject is a familiar one, I believe, and take the liberty of saying that I do not think the profession at large is taking it seriously in any practical way. I do not believe that they have yet realized that they should take a very active part in the move and do everything they can to further it. Of course, it is as yet in its embryonic stage, but if we are to progress in a medical way and maintain the influence of the profession as advocates of health we will have to appreciate the importance of fostering the movement by the co-operation of the medical profession as a whole. In other countries, particularly in the country to the south of us, it is receiving the organized and concerted effort of the medical profession in many directions; it has done so in the schools and, to some extent, in the insurance companies and the Life Extension Institute. And we in this country cannot afford to sit idly by and fold our hands, if we are going to make it succeed. In fact, it may be doomed to failure if our medical profession does not sympathetically and whole-heartedly co-operate.

Now, you all know what has been done by the Canadian Medical Association and by the different insurance companies—the very practical financial aid that has given it a good start. But the medical profession has to lead, and I would say that one of the first things the members of that profession should do is to undergo such periodical health examinations themselves and thus inaugurate the movement in a very practical way. In other words, we must practise what we preach.

The second point is that the members of the medical profession who are going to undertake this work should first qualify themselves to do it properly. Most of the practitioners of medicine are thoroughly familiar with many phases of this physical examination. Others are not so familiar, and these should qualify themselves conscientiously for this special mode of examination, which requires certain expert knowledge.

The third thing is that an examination of this kind is not a concrete and definite thing—not merely a physical examination. We have to take into consideration the personal equation, and unless the doctor who is making the examination is sympathetic with the patient, acting as his friend, and understanding his psychology, the thing is doomed to failure. I should like to emphasize that point. We have blank forms to fill in, but those are merely indications of the general plan. The psychological aspects, the environment, the occupation, and the home conditions are all factors of the utmost importance in these examinations. Let us not forget that normals vary all the time; that there is no such thing as a general normal condition, that each person differs from the other.

We also believe that the family doctor should make these examinations wherever possible; that is one of the axioms of the whole scheme.

Now, one of the things we as a profession should do to further this movement is to give it sane publicity in every way possible. I would mention among those efforts that we should introduce into the schools much more than we do the teaching of personal hygiene, explaining it to the children and to the teachers themselves, inculcating its principles in their minds. Then we should make use

of the press, furnishing it with very carefully studied articles as to the value of periodic health examinations. We should also avail ourselves of the radio, the platform and the pulpit. In all these ways, if the work is done seriously and carefully, the desired results will follow. Those who are going to do it from the pulpit should be given the material they are going to present so that it will not be done in any haphazard way. Then the universities must instil the idea into the minds of students, also introducing the necessary teaching among the graduates as to the technique of periodic health examinations. If, Mr. Chairman and gentlemen, we have the co-operation of the medical profession in this sane, wholehearted and sympathetic way that I have indicated, this plan, I believe, will be marked by success. Otherwise, as I have already intimated, it certainly is doomed to failure.

The Chairman: I omitted to state when introducing this subject that Dr. Martin, who has just spoken, is the chairman of the committee of the Canadian Medical Association which some four years ago undertook a study of the subject of periodic health examinations with the idea of producing something which would be an education to the medical profession. I will now call upon Dr. A. Grant Fleming, of Montreal, a member of that committee.

Dr. A. Grant Fleming (Montreal): I wish to bring to your attention, briefly, the activities of the Canadian Medical Association in the field of periodic health examinations. A committee was appointed under the chairmanship of Dr. C. F. Martin, and, after studying the subject, the first thing definitely recommended was the publication of a manual covering periodic examinations of apparently healthy individuals by the family physician. The principles adopted by that committee are these: First of all, that the examination is periodic; secondly, that it is the examination of apparently healthy individuals; and, thirdly, that it comes within the scope of the family physician. The manual was printed through the courtesy of the Department of Pensions and National Health, and distributed to the profession throughout Canada; a form for record is included. It is appreciated that no form satisfies everyone, and it is not suggested that there are no other ways of making such an examination. But this is one way, and it has certain advantages. We may standardize up to a certain point—with the approval of Professor Leacock—in this type of examination by the medical profession.

There is only one point I wish to mention with regard to the form. A record must be kept if the examination is to be of value from a periodic point of view, because it is by following the individual from year to year that we shall learn what can really be done in this field of periodic health examination.

Another thing the committee did was to prepare a motion picture for the purpose of visualizing to the profession the technique of such examinations, not with any idea of teaching actual methods of physical examination, but simply to demonstrate the actual procedure, to give some idea of the time it takes, and so on. Of course, there are some deficiencies in the motion picture, and if some day we can make it a talking picture, it will be much better. Then there are other means adopted; for example, through the medium of newspaper articles we bring to the attention of the public the need and value of periodic health examinations. And again, when people write to our Health Service, this gives us an opportunity to point out to them individually why they should go to their family physicians for examination periodically.

Dr. T. C. Routley (Toronto): It only remains for me to supplement what Drs. Martin and Fleming have told you with regard to giving practical effect to this very meritorious plan. For some considerable time we have been in negotiation with the insurance companies of Canada through the Life Insurance Officers' Association, particularly dealing with the health committee of

that organization. Upwards of two years ago we suggested to that committee a plan which in our judgment might make it possible for them to link their forces with ours to carry out periodic health examinations.

The plan, briefly, is this: The insurance company gives us the name of a client to whom it is willing to extend the privilege of a periodic health examination, the cost to be borne by the company. The client is advised by the insurance company that the offer is made; he is further advised that he will be communicated with by the Canadian Medical Association, who will inform him as to procedure. The procedure is this: We ask the client to nominate the doctor by whom he would like to be examined, and it is further stated to the client that the examination will be confidential; no report will be forwarded by the doctor to the Canadian Medical Association nor to the insurance company which would in any way jeopardize his present or future insurance. Upon receipt of the name of the doctor chosen by that client, the doctor is advised to get in touch with him and to carry out the examination. When the examination is completed the doctor submits to the Canadian Medical Association a report in which two questions are answered: 1. How long did it take you to make this examination? 2. Did you find any condition which by way of advice or treatment was worthy of correction? Answer—yes or no.

Now, the value of these two questions appeals to the insurance companies. In the first place, they as well as we are anxious to know how long it really takes to make a fair, honest physical examination. The insurance companies have told us emphatically at times, "Our fear is that the usual hurry-up examination will be made." They fancy that the health client will come in to his family doctor, and that a dialogue something like this will take place: "Well, doctor, here I am for this examination I have heard about." "Well, Charlie, I have known you for sixteen years and as far as I can see you're as right as rain." And so he slaps Charlie on the back, opens his vest, applies his stethescope, asks him about the family, tells him to say "Ninety-nine," writes down a few words—and that's that. Of course, an examination of that character would condemn the whole project. At a life insurance officers' convention held in Toronto a few days ago an executive of one of the prominent insurance companies in Canada told me he was not going to bring his company into the plan until he had some sort of evidence which would convince him that he was wrong in doubting that the doctors of Canada would do the thing as it deserved to be done.

One question which the insurance companies are asking is this: Whether or not any material value ensues from the plan. They would like to know what percentage of their clients find it worth while to be examined. And the other question they wish to have answered is the one I have stated: Did you find any condition which, by way of advice or treatment, was worthy of correction?

Our plan is fundamentally different from any other plan which has ever been offered to the clear-headed financial men of Canada who are in control of our insurance companies. Mainly in two particulars does it differ: first, it gives to the client the opportunity of choosing his doctor—and we have heard in the last two days about the importance of that relationship; and, secondly, the examination is confidential; the report to the client will be made by the examining doctor and not by a mail order service.

On January first next the system of periodic health examinations under the Canadian Medical Association comes into being. Four of the larger insurance companies of Canada have agreed to extend this service to certain of their clients; the Sun Life, the London Life and the Confederation Life and the Canada Life have definitely decided to take this step, and other companies are seriously considering joining hands with them. It would not be wise at this

juncture to name them, but I think I can say without very much hesitation that before many months go by these four companies will be joined by other large companies in Canada, and we shall probably have between fifty thousand and one hundred thousand clients to examine within the course of the next year or two.

The doctor is paid four dollars for the examination. The insurance company pays us six dollars, and we retain two dollars of this for the purpose of staffing the department and carrying on an intensive educational program destined, we hope, to educate the profession to its responsibility.

In my humble opinion, we are taking the most forward step in preventive medicine that has been suggested in this country in the last fifty years; and I venture to hope that before another decade passes this plan will have so fixed itself in the minds of the profession, and in the minds of thinking men and women in Canada, that mortality rates will have begun to decline, longevity will increase, and the health of the nation—referred to so pointedly by the Hon. Mr. Elliott in his able address of welcome yesterday—will be such as to leave no room for doubt as to the future of Canada.

Dr. McPhedran: Is this examination to be conducted according to any prescribed form? If not, I am afraid the thing will fall flat, and we shall have on our hands the condition which we have heard described—men walking into the doctor's office, being told they are all right, and nothing being done of any real value.

Dr. T. C. Routley: I thought Dr. Fleming had covered that point. I have in my hand the form which Dr. Martin, Dr. Fleming and their associates have drawn up. This form represents months of study, and a reference to all of the forms extant. It will be sent to the doctor, with instructions, when he is advised that the client has nominated him for the task. I believe Dr. Fleming has pointed out that it is not obligatory upon the doctor to use this or any other one form; but in sending this form we do recommend it as a guide in the examination. It has been suggested to us by the insurance companies that it would be well to consider, not at the beginning but probably at some date in the early future, asking the doctors to return to the Canadian Medical Association a copy of the form, without names, in order that, out of the large number of examinations made, statistical data might be put together, which would be of value both to the profession and to the insurance companies. That, however, remains for the future.

Dr. E. J. Boardman: Those of you who were here yesterday will understand, from the remarks I made then, that I am heartily in accord with the system of periodic health examinations; but I would point out that what has been undertaken so far must be regarded as only a preliminary. If we are going to derive any real benefit from periodic health examinations they must extend a long way beyond the examinations asked for by the insurance companies. When you are dealing with the clients of the insurance companies you are dealing with selected risks, the very best part of our national health; and in order that the periodic examinations may be of the utmost benefit to the community as a whole they must be of those who are uninsured.

I also wish to register my own personal dissent—I may be the only one—from the opinion that the general practitioner is the proper man to do this work. The general practitioner may do it, surely; but the general practitioner is a busy man, and if these examinations are to be of the greatest benefit to everyone there must be no hurry. The examiner must not be a man who is going to be called away to a confinement case, an accident, an emergency appendix or anything like that. Nothing will detract from the system so much as hasty examinations or deferred appointments; and if the general practitioner is to do the work, then such conditions will prevail.

In my opinion, the man who undertakes periodic examinations must be a specialist in periodic examinations. When the time comes that the great mass of the population of Canada are being periodieally examined, as we hope they will be, what are you going to do? In greater Winnipeg there are 300,000 people. If one man made ten examinations a day it would take thirty thousand days to cover that territory; if he worked six days a week it would require five thousand weeks; allowing him two weeks of holidays, he would work one hundred years to cover greater Winnipeg. It means that we must have, in greater Winnipeg, one hundred men making physical examinations from morning till night. Suppose the doctor gets $2 for each examination.

The CHAIRMAN: Four dollars.

Dr. BOARDMAN: This is my own proposal: it is not a financial seheme for the doctors but a system for the promotion of publie health. We think too much in terms of doctors, and I have been trying to think in terms of what is good for the people of the Dominion. Suppose he gets $2 for each examination and makes ten examinations a day, half an hour each: that would be five hours; and allowing him two hours for clerical work, that makes it a seven-hour day. At that he gets $6,000 a year, and that is not too bad.

Dr. FITZGERALD: I believe Dr. Routley omitted one important detail in connection with this matter of periodic health examinations. The health client is asked this question: In your opinion, was the examination worth while? Yes or no? And he is asked to return the answer to that question.

Dr. T. C. ROUTLEY: The feeling is now shared by the insurance companies that that method might be improved upon by a slight variation. The suggestion is that, rather than have us ask the client that question, the eompany should write to the client, say one month after the examination, a letter somewhat to this effect: "You have been examined by your doctor confidentially. Would you mind informing us whether, in your opinion, the examination was worth while?" At a meeting of the health eommittee held a few days ago one of the members of the eommittee made the point, that if the health elient were asked to make the return on the tripartite form suggested the doctor would tear it off and hand it to him, and the man would probably, right there in the presence of the doctor, sign his name and O.K. it; and that would not be as valuable a return as one made by the client days or weeks after he had had time to think the whole business over. That change has been suggested, and for that reason I left it out of the discussion. Personally, I think the suggestion of the insurance companies is better than the idea we originally had in mind; and when the eommittee decides upon it it will be my duty to bring it back to our health committee, of which Dr. Fitzgerald is ehairman, for approval.

Dr. BOARDMAN: One other objection I had to the general practitioner making the examinations. Certain people will be reeommended and eertain suggestions made; and if the general practitioner who suggests these things is the one to earry out the examination, some obloquy will be incurred by the profession in relation to periodic examinations.

Dr. A. J. MCGANITY (Kitchener, Ont.): I happen to have had something to do with insurance work, and I am not very enthusiastic for this seheme, speaking as medical director of an insurance company. There are too many loopholes. Dr. Boardman's suggestion will prove to be the solution; because, as we go along in insurance work, it begins to look as though, in every community, the insurance eompanies will all have examining specialists. The ordinary examination hardly justifies the insurance company in paying $4 to the doctor. Something should be taught in the universities about insuranee examination and what it is, because I am convineed that the majority of men

who make insurance examinations do not know why they are putting down certain answers to definite questions. One of our chief difficulties is in getting height and weight. We always ask the question: Have you weighed and measured this man?—and only too frequently the answer is, no. Such an examination is no better than I can make myself, sitting in my office without the client. The answer to this question is important as indicating whether or not the man is in good physical condition and is a safe risk; and unless these examinations are carried out by some one who knows how to make an examination, and how to bring out the salient facts in regard to health and general physical condition, they are not worth while. And the general practitioner is not in a position at the present time to make such an examination; he has to rush it, he does not know that the answers are significant, and he forgets to put down the facts that are of most importance.

Dr. C. E. Cross (Three Rivers): Dr. Routley stated that none of the information gleaned in these examinations would be divulged to the disadvantage of the client from the point of view of further insurance. May I point out, however, that questions are sometimes asked, the disclosure of the answers to which might not only militate against the client but involve a breach of ethics. I remember one question particularly, as to whether Wassermann's test should be made in a certain case. Are these things to be divulged? There should be no clash with the ethical relations of the doctor to his patient.

The Chairman: There is space on the record for the results of the Wassermann. I may observe that no one working on the committee or in the association puts forward this plan as something perfect. This is merely an introduction. It was very definitely decided that it was not the function of the Canadian Medical Association, nor of the medical profession, to undertake in any very active manner the eduction of the public. Our primary duty is, first of all, the education of the profession to the importance of periodic health examinations, and it is not confined to those who are insured; it is intended for the community at large. We felt that if we attempted anything in the way of an intensive education of the public there was a danger of our intention being misconstrued. The public, we thought, might say, "You get fees from us when we are sick, and now you want fees from us while we are well." The linking up with the insurance companies has been more or less fortuitous, and they have crowded us much more than we have crowded them. For one reason or another they have felt that whatever periodic health examinations of their policy holders have been carried out in the past have been productive of very small results. Only a very small percentage of their policy holders have availed themselves of the opportunity for periodic health examination in the past, and the cost has been borne by the insurance companies. We felt—and they felt too—that probably the failure in the past has been due to the fact that the policy holder was compelled to go to a certain doctor who was directly or indirectly appointed by the insurance company.

We think that this is an opportunity whereby the thin end of the wedge of education can be introduced, so that finally the whole community will be reached. As a rule, insured people are the thinking people. If the policy holder gets what he considers a worth while examination, and particularly if he receives good health advice following upon his examination and the discovery of improper habits of eating or drinking or living generally, as a thinking man he is going to realize that what is good for him is likely to be good for his family. And so we welcome this plan suggested by the insurance companies as an indirect method of educating the general community to the advantages of periodic health examinations.

Dr. T. C. Routley: I should like to go on record as having faith in the general practitioners of Canada. I am sure that what we have heard at this conference, and in other years, has been said in all sincerity—that the sheet anchor of medicine in this country is the family practitioner. Surely, then, if we believe that, it is possible for us to overcome any obstacles that might prevent the general practitioner from doing this work, and from doing it well.

It seems to me that consistency is something we should keep before us. We shout from the housetops, from coast to coast, "The family doctor, the general practitioner, must be retained." Well, let us give effect to that conviction. Here is an opportunity for us to help the general practitioner; and if he needs education let us give it to him. I sincerely believe the plan will succeed, simply because I believe that the medical profession of this country can "put it across."

At one o'clock the conference took recess.

FRIDAY AFTERNOON SITTING

The conference resumed, Dr. Bazin in the chair.

The Chairman: If you will come to order, gentlemen, we will have a report from the Chairman of the Resolutions Committee, Dr. H. E. Young.

Dr. H. E. Young (Victoria): Mr. Chairman and gentlemen, your committee desire to submit the following resolutions:—

Resolution No. 1

The Third Conference on the Medical Services in Canada, composed of delegates from all the provinces of the country, and representative of its many medical activities, desires to place on record its sincere appreciation of the courtesy of the Honourable Doctor J. H. King, Minister of Pensions and National Health, and of the speaker of the House of Commons, in placing at the disposal of the conference an assembly room in the House of Parliament, in furnishing stenographic reports from the Hansard staff, and for the generosity of the Government in undertaking the cost of publishing the proceedings of the conference.

The Chairman: You have heard the resolution moved by Dr. Young and seconded by Dr. Ferguson. Shall the conference pass that resolution?

Resolution approved.

Dr. H. E. Young: The next resolution I shall read relates to the question of drug addicts.

Resolution No. 2

Whereas the Conference on Medical Services in Canada regrets the deplorable lack of accommodation in Canada for the treatment of drug addicts, we beg leave to request that the Canadian Medical Association suggest to the various provincial governments the desirability of amending their Hospital Acts in such a way as to make provision for the care and treatment of drug addicts in such institutions as the Government may designate for this purpose, and that such institutions be empowered to retain these addicts as being legally committed for such periods of time as those in charge of their treatment may deem necessary to secure the best results. Furthermore, that such designated institutions be properly reimbursed for the added expense of properly caring for such drug addicts.

Dr. J. S. McEachern (Calgary): Mr. Chairman and gentlemen, I am in full agreement with the general tenor of this resolution, but am of the opinion

that it is going to be out of the question for all general hospitals to treat these cases with one case going to a general hospital in one town and perhaps two or three other cases to a general hospital in the adjoining town and so on. It seems to me that an improved suggestion would be for the resolution to recommend that three or four general hospitals in the Dominion of Canada be set apart for the treatment of drug addicts, and that the Dominion Government, which has been responsible for placing these people in the category of a cross between criminals and invalids, should carry at least half of the cost of such treatment and the respective provinces the other half. I would suggest that there should be, say, one in Western Canada, one in Eastern Canada, and one in the central part of the country. In this way, those in charge of the selected hospitals would have the opportunity of acquiring experience in the handling of such cases and become expert in it in a short time; whereas if every general hospital were permitted to take them in, no one would have a chance of acquiring the necessary skill in dealing with them.

Dr. G. Harvey Agnew (Toronto): Might I just point out that the wording of the resolution under discussion makes no reference to general hospitals. In the course of yesterday morning's session, the thought was expressed that the general hospitals in Canada might be requested to take on the care of these patients, but your Resolutions Committee, in drafting this resolution for your approval, thought that it would be better not to make reference to general hospitals or any other public institutions, but just to word it, "Such institutions as the Government may designate for the purpose." Moreover, in drafting this resolution we felt that we should incorporate in it the express desire that any such hospitals so designated by the Government—again we avoid mentioning either provincial or Dominion—should be fully compensated for the very heavy burden that would thereby be entailed.

The Chairman: This conference, of course, has no executive powers. We can pass resolutions expressing opinions or making recommendations, but these have to be implemented by referring them to some authoritative body to deal with. Now, if we add to this resolution that this conference suggests or recommends to the Canadian Medical Association that they take steps to follow up these recommendations as outlined in the resolution, I think that would meet the approval of members of this conference.

Dr. FitzGerald: Mr. Chairman, I was wondering if the resolution could recommend that judges or courts be empowered to send drug addicts to hospitals for treatment instead of committing them to jail for punishment, as I have seen done—sometimes at the instigation of relatives?

Dr. H. E. Young: That is provided for Mr. Chairman—"That such institutions be empowered to retain these addicts as being legally committed," etc.

Resolution approved.

Dr. H. E. Young: The third resolution relates to the hospital care of mariners, and reads as follows:—

Resolution No. 3

The Conference on the Medical Services in Canada learns with gratification that the care of sick mariners comes within the purview of the federal Government through its Department of Pensions and National Health, and also that the Government imposes upon vessels arriving in Canadian ports, a tax to defray the hospital, nursing and medical cost of caring for such patients. The conference would, therefore, most respectfully submit for the consideration of the Minister of Pensions and National Health that the tax levied upon the vessels be made adequate to enable the fund to remunerate the members of the medical

profession responsible for the care of such cases by the payment directly to the doctor, of fees which shall be at least equivalent to those of the Workmen's Compensation Boards in those particular provinces, and that, in the meantime, in those cases where a composite, all-embracing fee is paid to the hospital, the federal Government insist upon the proper division of this fee with the attending surgeons or physicians.

Resolution approved.

Resolution No. 4

The fourth resolution reads as follows:—

The Conference on the Medical Services in Canada desires to pay special attention to what the chairman, Dr. A. T. Bazin, had to say upon the important topic of the Post Graduate Lectures that have been given for several years under the auspices of the Canadian Medical Association, through the generosity of the Sun Life Assurance Company of Canada, and would express the hope that these valuable lectures may be continued, and would so desire to record the feeling of this conference.

Resolution approved.

Resolution No. 5

Whereas the discussion of the problems presented to this Conference on Medical Services has demonstrated the value of and the need for such periodic consultation of representatives of the various medical bodies and organizations, be it resolved that this Conference on Medical Services in Canada request the Canadian Medical Association to continue these conferences at such intervals as may be decided by its council.

Resolution approved.

Resolution No. 6

That those worthy of it may receive this merited meed of praise, it is resolved that a very hearty vote of thanks be recorded for the valuable services of Dr. Alfred T. Bazin and Dr. T. C. Routley, in bringing the Third Conference on the Medical Services in Canada to such a successful fruition.

Resolution approved.

The Chairman: Dr. E. S. Ryerson will now introduce the subject of

MEDICAL LICENSURE

Dr. E. S. Ryerson (Toronto): The idea of having one examination for licence to practise medicine anywhere in Canada has existed for a great many years. As long as thirty-eight years ago, there appeared an editorial in the *Canada Medical Record* (published in Montreal in March, 1891, when Dr. A. Lapthorn Smith and Dr. F. Wayland Campbell were the editors), suggesting the idea in the following words:—

"During our last visit to England a patriotic Canadian who has risen high in the London medical profession urged upon us the propriety of advocating a single portal to practise in Canada. Great difficulties stand in the way of the realization of this idea, but they are not insurmountable, while on the other hand the advantages would be very great." . . . "There would be to some extent a saving of expenditure or a concentration of energy, for instead of having eight examining boards, we would have one examining board composed of the very ablest men in each department.

"The university (it suggested that this body be called the University of Canada instead of the Medical Council of Canada) would consist of examiners only, not teachers, who would be elected by the professors of all recognized schools, and who would meet in Montreal during the first week in May of every year. The objection would come from the candidates who might be inclined to place personal convenience before patriotism and the general welfare, and who would be obliged to travel from all the outlying teaching centres to the metropolis for examination. But this would only be once in a lifetime."

Eleven years later, in 1902, this idea was placed on the statute books of Canada through the activity and energy of the late Dr. T. Roddick as "The Canada Medical Act."

In his presidential address to the Canadian Medical Association in 1912, Dr. H. G. MacKid, of Calgary, said:—

"The Roddick Bill aims at the establishing of one set of examinations and one standard of qualifications for the practice of medicine in Canada, in place of the different examinations and varying standards of the individual provinces. It was introduced in the House of Commons in 1902 by Dr. Roddick, then representing St. Antoine Division, Montreal. The Bill was passed, but owing to objections raised to certain features by provinces jealous as to their existing rights, it was found impossible to give effect to the Act.

"During the present spring (1912) the so-called "Enabling Clause" was finally passed in Ontario, the last of the provinces which had previously been afraid that their provincial autonomy would be endangered and I am glad to be able to say that we are finally in a position to begin the detail work of arranging for a Dominion Council."

In June, 1912, an editorial in *Canadian Journal of Medicine and Surgery* commented on adoption of enabling clause by Legislature of Ontario, as follows:—

"As far as licence to practise goes, candidates would derive no advantages from passing a provincial examination, in addition to a Dominion one, the scope and privileges of the latter including the former, while the examination would be practically no harder, *one final examination being enough.* The Provincial Medical Council will have less to do, although they can still find very profitable employment in prosecuting quacks, etc." . . . "Whatever causes—national or linguistic—may have separated practitioners in the past, for the future they will march under one flag, decorated with one professional badge, and devoted to one office—the greater good of scientific medicine in Canada."

Since its inception in 1912, the Medical Council of Canada has been an enormous success. The number of candidates for its Licentiate has grown steadily, as shown by the following figures kindly furnished by the Registrar of the Medical Council, Dr. J. Fenton Argue:—

1917	40	wrote and	17	passed
1918	31	"	17	"
1919	24	"	17	"
(No figures for October, 1919, examinations).				
1920	102	"	67	"
1921	117	"	94	"
1922	115	"	93	"
1923	131	"	95	"
1924	300	"	248	"
1925	202	"	171	"
1926	343	"	252	"
1927	283	"	224	"
1928	325	"	265	"
1929	378	"	318	"

This year, 378 graduates presented themselves, constituting a large majority of the students who took their degrees at Canadian universities this year. During this period the high standard of its examinations has been maintained unswervingly. The financial difficulties with which it had to contend in its earlier existence have now reached a state of comparative stability. The members who have served on this council are to be congratulated on their interest, determination and self-sacrifice to make it a success.

Successful as it has been, the objective and ideal of one portal of entry to the practice of medicine in Canada has not yet been reached.

Licence for the practice of medicine in all provinces can now be obtained by obtaining the Licentiate of the Medical Council of Canada.

In one province only, British Columbia, is this the only channel through which registration can be obtained.

In the other eight provinces, in addition to registration through the L.M.C.C., it may be obtained by the following methods:—

I. Method.

A. That whereby the examination of candidates for admission to practise medicine is under the control of the University of the province, the examiners for the purpose being appointed by the university.

This exists in the provinces of Alberta, Manitoba and Saskatchewan.

B. For the purpose of examining candidates for the practice of medicine, a board shall be established called "The Medical Board of Examiners," two-thirds of whom shall be professors of the faculties of medicine of the universities and one-third representatives of the College of Physicians and Surgeons of the province.

This exists in the province of Quebec.

II. Method.

Registration for licence to practise medicine is obtained by passing examinations conducted by the College of Physicians and Surgeons of the province concerned.

This exists in Ontario, New Brunswick, Nova Scotia, and Prince Edward Island.

Describing this in general terms, there is one province requiring all candidates to take the examination of the Medical Council of Canada.

There are three provinces in which the licensing body accepts the examinations of their own university.

There is one province in which two-thirds of the examining board is appointed by the university and one-third by the licensing body.

There are four provinces who conduct provisional licensing examinations, in addition to the university and Medical Council of Canada examinations.

The question for consideration is whether the time has not come when the examinations of the Medical Council of Canada should not be the only standard accepted by all the provinces of the Dominion for licensure.

In the former group, the objection might be raised by students from Alberta, Saskatchewan, and Manitoba that making the L.M.C.C. compulsory would force a certain number of the graduates of their universities to pass a second examination and pay an extra fee of $100, when such men could practise in these provinces without doing this.

A study of the reports of the Medical Council of Canada shows that the vast majority of the graduates of the universities in these provinces have been taking the examination for the L.M.C.C. (and paying their $100) even though it is not compulsory. They appreciate the many advantages of possessing the standing that the L.M.C.C. gives them and are prepared to make sacrifices of energy, time and money in order to obtain the desired certificate. Little or no injustice would therefore come from this standpoint.

Another difficulty which arises is the equitable distribution of the fees paid by the candidates between the Medical Council of Canada and the Provincial Medical Councils. The problem is whether the arrangement entered into between the Medical Council of Canada and the Provincial Board of British Columbia, whereby a rebate of $25 per candidate is made to British Columbia by the Medi-

cal Council of Canada should be considered as a precedent that is insurmountable and ought to be adopted for all provinces who require the L.M.C.C. as the only method of obtaining registration in a province or whether it is not possible to devise some other distribution of the receipts for examination and licence to practice, which would be satisfactory to both the contracting parties.

The adoption of this method by British Columbia whereby all candidates must obtain their licence in that province by obtaining the L.M.C.C., fulfills the purpose for which Dominion registration was introduced by Dr. Roddick and passed by the Dominion Parliament in 1902.

The proposal is now made that the other eight provinces should follow the lead of British Columbia and require all candidates in the respective provinces to pass the examinations of the Medical Council of Canada.

The objections to and difficulties in the way of taking this step by the other provinces are dependent in some degree upon the two methods at present operating in these provinces.

As shown above, in four provinces (Alberta, Saskatchewan, Manitoba and Quebec) the examinations of their respective universities for obtaining the degree of medicine are accepted by the provincial licensing body, and the right to practice in their province granted on the basis of this one examination.

In the other four provinces, the provincial boards are conducting provincial examinations in addition to those of the universities and the Medical Council of Canada.

If all candidates were required to qualify for licence by taking the Medical Council of Canada examination, the fees they would have to pay for the L.M.C.C. and examination and provincial registration at the present time would amount to:—

British Columbia	$150
Alberta	150
Saskatchewan	150
Quebec	150
Nova Scotia	150
New Brunswick	140
Prince Edward Island	120
Manitoba	200
Ontario	200

The average of the above amounts is 156, suggesting that an average fee of $150 is roughly that paid by students in Canada now.

Before the establishment of the Medical Council of Canada, $100 was the maximum sum paid in any province. I feel certain that the increased amount the recent graduate now has to pay has deterred a considerable number of good students from taking the L.M.C.C., although they fully recognize the advantages of possessing this qualification. I am confident that Dr. Roddick and those responsible for the Medical Council of Canada thought that, when the Medical Council of Canada became operative, the Provincial Councils would drop their own examinations and in this way be relieved of the expense of conducting such examinations, and hence be in a position to reduce the fees charged students. Only in British Columbia has this action been taken so far. In the earlier days of its operation, the Medical Council of Canada had to charge a fee that would be sufficient to pay for (*a*) the expenses of the examination and (*b*) the expenses of the administration of the council and with the small number of candidates during the first few years, this body had financial difficulty in making ends meet. More recently with the greatly increased number, this situation of financial stringency has been gradually passing off. If the number of candidates were further increased so that all graduates of Canadian Medical Colleges took the examination, I think it might even be possible for the L.M.C.C. fee to be reduced to say, $75. If this were done and the various provinces charged

a fee of $50, then the recent graduate would only have to face a total expenditure of $125 for his L.M.C.C. and his licence to practice in any one of the provinces.

Could the Medical Council of Canada carry its examination, administration and other expenses on a fee of $75? This might be calculated fairly accurately by estimating the probable receipts for the coming five years, if all Canadian graduates took their examination. In 1928, the number of medical students in attendance in Canada was 2,573. Allowing for a wastage of 25 per cent this would mean that 1,930 students would graduate in the next five years or 386 per year, which at $75 each would amount to $28,950 per year, which should be ample for its maintenance.

As seven out of nine province have a fee now of $50 or less, their income would be unaltered, whereas Ontario and Manitoba would have to reduce their fee from $100 to $50. It is to be hoped that these provinces would be willing to take this step for the benefit of the future of medicine in Canada.

Another point of view from which the double fee for the L.M.C.C. and registration in a province is worthy of consideration is that of the graduating student who has to pay it. He can understand why a certain fee for obtaining a licence to practice in a province is a reasonable procedure. He can appreciate why a charge for an examination has to be made to cover the expenses thereof. But what he does not think is either reasonable or just, is that one man can take his provincial examination and obtain his licence on payment of a fee of $100, as in Ontario, while another man who takes the Medical Council of Canada examination and pays $100 for its Licentiate still has to pay another $100 to the Provincial Council for his licence to practice. One man pays $100 another $200 for practically the same thing. Only by persuading him of the many advantages of having the right to obtain his licence anywhere in Canada, can he be induced to pay the extra $100. The fact that so many graduates pay the $200, even though they do it grudgingly and resentfully, feeling that there is not a justification for such a charge, speaks well for the broad vision and foresight and patriotism of the oncoming members of the medical profession.

In June, 1929, 378 candidates came up for the examinations of the Medical Council of Canada, the majority of whom came from a total of 406 graduates of Canadian medical schools.

In some universities, practically 100 per cent of their graduates take the L.M.C.C. In Toronto, I have been personally advising every student who possibly can raise the funds to take the L.M.C.C. and am becoming more successful each year.

I feel that the honour of having the L.M.C.C. should be so appreciated that all graduates would be ambitious to have it just as they now are ambitious for the degree of M.D. from their university. Persuasion and inducements should not have to be used and I am confident that if the fee can be so fixed that it approximates what can be considered a reasonable charge for the purpose for which it is paid, that the future members of our profession will welcome the adoption of regulations in all provinces, by which their licence to practice must be obtained by passing the examinations of the Medical Council of Canada, and I think I am safe in saying that the payment of $125, composed of $75 for the L.M.C.C. and $50 for registration in a province, would meet with the general approval of medical graduates of the future.

Prior to the establishment of the examinations by the Medical Council of Canada, in 1912, certain of the provinces hesitated to give Dominion registration their endorsation, because they were in some doubt as to whether the standard of the examinations of the Medical Council of Canada would be as high as that which their provincial examinations had had. That they had no

grounds for such an apprehension has been demonstrated by the high character and standard of these Dominion examinations since their inception in 1912.

There is still less reason at the present day for the provincial licensing bodies having any fear whatsoever that the abolition of their provincial examinations and the substitution of those of the Medical Council of Canada for them, would in the slightest degree lower the standard of medical knowledge of those who become licensed through the Medical Council of Canada.

The adoption of one uniform method of obtaining a license to practice medicine in all of the Canadian provinces by taking the L.M.C.C. and registering in a province can become an accomplished fact if those representing each of the provincial licensing colleges or councils will recognize that the ideals and hopes of Dr. Roddick and those who succeeded in making Dominion Registration possible by the passing of the "Canada Medical Act" in 1902 and "The Enabling Clauses" in the various provincial legislatures, will not be fulfilled until all the provinces require the L.M.C.C. as the only portal of entry to the practice of medicine in their domain.

Should the objective of providing the L.M.C.C. as the one portal of entry to the practice of medicine in Canada be attained, the way whereby the ideal of enabling the graduating student to obtain his degree and his licence by passing one examination will be made more feasible. The boards of examiners of the Medical Council of Canada each and all include university men and practitioners. The appointment, by Universities, of practitioners as extra-mural examiners in each of the subjects would improve the character and standard of the university final examinations. Such a principle is a recognized one in Great Britain, and is the custom at such universities as Oxford, Cambridge, Edinburgh, etc. It is also in operation in the province of Quebec, where one-third of the board of examiners at each of the universities consists of practitioners appointed by the College of Physicians and Surgeons of that province. It is possible that a similar arrangement between the Medical Council of Canada and the universities might be acceptable to the Quebec authorities or even that some such arrangement would be the one that would satisfy all the provincial councils.

If the Medical Council of Canada appointed the boards of examiners, say, for the Montreal examination and the Universities of Montreal, Laval and McGill appointed the same boards of examiners for their final examinations, then the candidates might be examined by these boards and those who passed, be granted their degrees by their respective universities. Then the same students would present themselves two weeks later for the examinations of the L.M.C.C. before the same boards of examiners. This does not sound very sensible, but it is almost an exact description of what is actually happening each year at the various centres where the Medical Council of Canada examinations are held, because many examiners are both the University and Medical Council of Canada examiners.

Instead of re-examining all the candidates a second time, might it not be possible for the boards of examiners, which have been appointed by both the university and the Medical Council of Canada, to reconvene and again pass upon the results of those who have been granted their degrees by the universities recommending to the Medical Council of Canada first, the names of those candidates whom they deem worthy of their Licentiate, and, second, the names of the candidates who are to be required to present themselves at a future date for re-examination. Such a proceeding might be considered perfectly regular and might obviate the necessity for any amendment to the Canada Medical Act or any of the provincial Acts.

The medical profession of Canada and of each of the provinces have succeeded in uniting themselves into one organized body, the Canadian Medical Association, with its constitutent provincial and county medical associations.

Yesterday, the Royal College of Physicians of Canada and the Royal College of Surgeons of Canada came into existence as organized bodies of the Physicians and Surgeons of Canada. Surely the time is more than ripe when the Dominion and Provincial bodies concerned with licensure to practice can get together into a similar organized Canadian body which will accept the examinations of the Medical Council of Canada as the one portal of entry to practise in Canada.

The making of every graduate of a Canadian university a Canadian practitioner qualified to practice anywhere in his native country is an objective worth attaining. Its accomplishment will require a spirit of co-operation, a spirit of give and take, a little self-sacrifice here and a little self-denial there, a spirit of trust and confidence in the sincerity and honesty of others, a spirit of courage and determination to succeed in reaching a desired objective, an intention to devise ways and means which will provide the greatest good for the greatest number, and as the objective is a most worthy, desirable and reasonable one, let everyone put his shoulder to it and make it an accomplished fact.

REMARKS ON THE CANADA MEDICAL ACT

G. C. Van Wart, M.D., L.M.C.C. (Fredericton, N.B.): The Secretary of the Canadian Medical Association, Dr. T. C. Routley, asked me to make some introductory remarks on the Canada Medical Act, but on the program it is called Medical Licensure. Under the terms of the British North America Act, each province controls its own educational affairs, this includes Medical Licensure. All the provinces are more or less jealous of their autonomy. I will confine my remarks to the Canada Medical Act. Under the provisions of this Act, the Medical Council of Canada is constituted. The Council consists of 33 members, as follows: Three are appointed by the Governor in Council; one from each medical school; two from each province; three represent the Homeopaths. The term of office for members is four years.

Its Purposes: Sec. 5.

The purpose of the Council shall be to promote and effect:—

(*a*) The establishment of a qualification in medicine, such that the holders thereof shall be acceptable and empowered to practise in all the provinces of Canada;

(*d*) The establishment and maintenance of a board of examiners for examination and granting of certificates of qualification;

(*e*) The enactment, with the consent and at the instance of the medical councils of the various provinces of Canada, of such provincial legislation as is necessary to supplement the provisions of this Act and to effect the foregoing purposes.

Candidates Eligible for Examination: Sec. 12.

(*a*) No candidate shall be eligible for any examination prescribed by the council, unless he is the holder of a provincial licence, or unless he presents a certificate from the registrar of his own provincial medical council that he holds a medical degree accepted and approved of by the medical council of the said province.

(*b*) The standard of examination shall not, at any time, be lower than the highest standard for the like purpose then established for ascertaining the qualification for registration in any province.

EXAMINATIONS: Sec. 16.

The subjects of examination and the eligibility of candidates shall be decided by the council, and the candidates for examination may select to be examined in the English or French language. A majority of the committee conducting the examination of any candidate shall speak the language in which the candidate elects to be examined;

(2) Examination may be held only at those centres at which there is a university or college actively engaged in the teaching of medicine or having hospital facilities of not less than one hundred beds.

Sec. 24. No amendment to this Act may be proposed on behalf of the council unless previously accepted by the provincial medical councils.

The Medical Council of Canada was first legally constituted under the Canada Medical Act, 7th of November, 1912. Any person who was duly registered in any province of Canada prior to November 7, 1912, but who was not so registered ten years prior to that date may be registered by the Medical Council of Canada, either by examination or without examination on the completion of ten years after the provincial registration. Any person whose first provincial registration is subsequent to November 7, 1912, can become registered only by passing the examinations of the Medical Council of Canada.

Any person who secured registration on the Medical Register of Canada by medical registration of ten years' standing, is entitled to register without further examinations in any province, by conforming to the provincial requirements of the necessary fee, etc., but the provincial council may exact an examination in final subjects, and such an examination shall be held according to the provisions of the by-laws or rules of the respective provincial councils. Sec. 18, clause 2.

It was the hope of those who established the Canada Medical Act that at some period, not for distant, the legal right to practice medicine in Canada would be only by taking the examination of the Medical Council of Canada. Those who are registered in the Canada Medical Council Register have the qualification of Licentiate of the Medical Council of Canada—L.M.C.C.

This national qualification is the only one that is acceptable in all the provinces for registration to practice. Examiners are selected from teachers in medicine and practitioners with due regard to ability and experience. The candidate being the first consideration; the time and place of examination is carefully chosen. Once a year the examinations are conducted in French, as well as in English, in the city of Montreal.

In 1930 examinations will be held in Halifax, Montreal, Kingston, Toronto, London, Winnipeg, Edmonton, Vancouver.

October, 1930, examination will be held in English and French in Montreal; and in English in Winnipeg.

The subjects are five, namely:—

1. Public Health and Preventive Medicine.
2. Pathology and Bacteriology.
3. Obstetrics and Gynaecology.
4. Medicine, including Therapeutics.
5. Surgery.

REGISTRATION

During the period of the Great War, 1914-1918, registration was not very marked. The total number on the register in 1921 was 720; in 1925, 1,471; 1928, 2,296; October, 1929—for the year 1929 to date, 2,620—278 in June and 44 in October registered through examination, also ten through the ten-year clause—for the year, to the present time—332.

I regret to state that there is an occasional criticism of the *modus operandi* of the council. This, I think, is due more to a lack of knowledge of the constitution and regulations of the Canada Medical Act. The number of candi-

dates is yearly increasing. The attitude of the medical schools and provincial boards have changed of recent years. This is a sufficient answer. The functions of the council are clearly defined. It has no authority to dictate or make any suggestions to the provincial boards. It should be clearly understood that it has nothing whatever to do with the requirements of Matriculation of Medical Students, Medical Curricula, Degree or Provincial Examinations. It is an examining body only and has no authority to grant a licence to practice. It has no affiliations or subsidiary status.

The question of conjoint examinations of Canadian Medical Schools, Provincial Medical Councils, and the Medical Council of Canada is being advocated. If all the Provincial Medical Councils would first suspend their examinations and make the L.M.C.C. the only portal of registration, much more would be accomplished.

Let all the Provincial Medical Councils advise their candidates to take the L.M.C.C. examination. This is the attitude of the Council of Physicians and Surgeons of New Brunswick. The College of Physicians and Surgeons of British Columbia entered into an agreement with the Medical Council of Canada in 1919, and this is apparently working very satisfactorily. At the last Annual Meeting of the Medical Counicl, the College of Physicians and Surgeons of Ontario asked for an agreement similar to that of British Columbia. This request I hope will receive very sympathetic consideration.

In conclusion, I do not think that the time is yet opportune to amend the Canada Medical Act for conjoint examinations. The matter is not so easy of adjustment as it apparently seems. Experience has taught that it is often easier to get legislation than to make subsequent amendments to an Act of Legislature. The Council wishes always to harmonize with the medical profession of our great country. Any proposed changes should first be agreed to by the nine provincial medical councils before legislation is sought. Sec. 24.

Dr. Primrose: If I understood Dr. Van Wart correctly, practically one-third of the medical men practising in Canada to-day get their licences primarily from the Dominion Medical Council. That is a remarkable fact; it means that the younger men are taking that examination.

With regard to the provincial councils, they were instituted at a time when they were absolutely needed; they did splendid work, and were essential to the maintenance of standards. They were established at a time when it would have been impossible to hold such a conference as we have been having in the past two days to discuss matters affecting various parts of the country. The work they did was necessary, and they did it very satisfactorily. There was a gradual evolution, and later on came the Medical Council; and now we are aiming at a still higher ideal, as Dr. Ryerson points out, so that the time is coming when we shall have one examination instead of two for the unfortunate individual who has to apply for a licence. The examiners of the Dominion Medical Council are largely the examiners who examine these men for their M.D. degree. It might be well to ascertain how many men there are, rejected by the universities, who pass the Dominion Medical Council and, on the other hand, men who pass the universities and are rejected by the Council. I am quite sure that such a study would show the results obtained to be more or less accidental. Therefore I believe that the sooner we adopt the policy of the Mother Country the better for Canada, establishing the principle that a graduate of a university is qualified to have a licence under the Dominion Medical Council.

The Chairman: There is one matter of importance which I wish to bring to your attention. The representative of the Canadian Press would like to have it made clear to the members of this conference that the actual report which he sent to the press regarding the discussion of yesterday was this:—

"A number of papers dealing with national health insurance were read, and these disclosed a considerable agreement of opinion on the part of speakers with regard to the necessity for such a system. The work of British Columbia in connection with provincial aid was alluded to, and the facts show that in matters of this character the three westernmost provinces are greatly in advance of the more conservative east. Weaknesses in the British panel system were pointed out, but it was felt that lessons could be learned from such weaknesses, and that Canada need not necessarily copy them."

That was the text of the report which the representative of the Canadian Press furnished, and any descriptive headlines or other statements appearing in the newspapers were added without his authority or the authority of anyone with any knowledge of what transpired in the course of the proceedings yesterday.

SURVEY OF NURSING EDUCATION IN CANADA

By Dr. G. Stewart Cameron

(Read by Dr. T. C. Routley)

At the last meeting of the Conference on Medical Services held in March, 1927, a paper was presented dealing with some of the phases of the nursing situation in Canada. In this paper, it was recommended that the Canadian Medical Association be asked to sponsor a meeting of representatives of the Canadian Nurses' Association and of the Canadian Medical Association. This recommendation was acted upon by the Canadian Medical Association at once and a conference of the two organizations was held in Toronto during the meeting of the Canadian Medical Association in June of that year.

As a result of this joint conference, it was agreed that each association should appoint three members who would act upon a joint board for the mutual consideration of a survey of nursing throughout the whole of Canada. This committee was duly appointed—the personnel being Misses Gunn, Browne and Russell, representing the Canadian Nurses' Association, and Doctors Bazin, Duncan, Graham and G. S. Cameron, being the appointees of the Canadian Medical Association.

This committee met in the following September for organization and during the subsequent months held a number of meetings. The following points were unanimously agreed upon:—

1. That a national survey of nursing should be made.
2. That is should embody investigation, in the widest sense, of the nursing profession, in their contacts with the hospital, with the public and with the medical profession.
3. That this survey should be made by an independent person—an educationalist being secured if at all possible.

The chief difficulty confronting the board from the start was the matter of funds. Various possibilities were investigated but without success. Finally it was brought home to the conference that if anything was to be done, they must rely upon their own resources. Consequently the Canadian Nurses' Association made a preliminary contribution of $5,000, the Canadian Medical Association $2,500, and the Ontario Medical Association $1,000. The nurses felt that as the result of the survey would probably be of more benefit to them than to any other persons, it was only fair that they, as a body, should contribute the largest portion of the money. I think, in view of this fact, the medical profession is in duty bound to see that this survey is carried through in a satisfactory manner.

Dr. George Weir, Dean of the Faculty of Education in the University of British Columbia, was chosen to do the work. He began his studies on November 1 of this year. He is employed on full time for a portion of the survey and on part time for the balance.

He began his work in Toronto, where he is making his plans and getting his organization together. It is his intention to visit all sections of Canada so as to personally come in contact with those interested in the question. I believe it is his intention also to visit certain groups of hospitals and training schools in each province so as to familiarize himself with the exact conditions.

It might be pointed out that this is one piece of work that can be said to have had its inception in this Conference of Medical Services. We would ask that the widest assistance, therefore, be given Dr. Weir and the joint study committee in their efforts to bring to a successful conclusion this national survey.

Dr. J. H. Elliott (Toronto): Dr. Stewart is not able to be present but he felt that, as the Canadian Tuberculosis Association had received an invitation to participate in these discussions, something might be added, under the subject of health and the state, in which our association is more particularly interested. He forwarded a rather concise summary of suggestions, to which we have added a few other matters. The gentlemen who are interested particularly in public health are not here this afternoon, and with your permission, Mr. Chairman, I should like to leave this memorandum with you rather than read it.

PREVENTIVE MEASURES IN TUBERCULOSIS

Though there was a steady decline in the death rate from tuberculosis previous to the demonstration by Professor Koch of the tubercle bacillus as the causative organism, it has been conclusively demonstrated in many communities in Canada and elsewhere, that the application of preventive measures based upon our present-day knowledge of the causes of tuberculosis, has resulted in a marked and rapid further decline in mortality rates from this disease.

The effectiveness of a proper public health campaign against tuberculosis has been so apparent that the Canadian Tuberculosis Association feels it should make a contribution to this conference in the symposium on prevention.

Doctor Stewart, our president, is unfortunately confined to his bed, but he has forwarded the following terse communication to which I add two paragraphs:—

"Our chief interest in the present conference is, of course, Health and the State, though we are interested also in medical education."

My own views, which I think are likely pretty general among our men, are given in various publications, including new annual report (Annual Report, Manitoba Sanatorium, 1928-29)—which I have just sent.

I think that, important and essential as the sanatorium is, the consequent of tuberculosis demands much more than the sanatorium. It takes clinics, and lots of them, local and travelling. The aim should be not to do a little spurt here and a little spot there, but to do the job thoroughly. Here are some of the essentials:—

Every "contact" and every suspect examined, with use of X-ray plates;

Every "contact" and every suspect followed up, taught, re-examined;

Every tuberculous person known and kept track of;

Sanatoria enough for treatment of all who need it, for as long as they need it;

Sanatoria and hospitals for segregation of all who cannot otherwise be sufficiently made safe for as long as they are unsafe;

Popular teaching by spoken and written word about tuberculosis and infections generally, and about general laws and rules of health;

Routine examinations of all hospital staffs and of all university students as a means of putting routine examinations over with the people;

Medical men now in practice taught to make routine examinations;

Medical students given the " preserve health " point of view, as well as the " cure illness " point of view.

It will be seen that the anti-tuberculosis campaign merges into a general health campaign. Anti-tuberculosis workers thought they were tackling one disease only, intending to start on others later. What they have actually done has been to take one outstanding disease, tuberculosis, as an example, and demonstrate from it; to take one outstanding disease, tuberculosis, as a text, and preach from it.

Even if not one life had been saved from tuberculosis, the anti-tuberculosis campaign has been worth all it has cost for what it has done in general health education.

A sanatorium to do its duty cannot be self-contained, like a ship at sea, but will be in constant helpful relations with its surroundings, its parish. Its doors will swing freely inward for all who come for help, and just as freely outward with help for those who do not come, or who do not even know their need.

Every case of tuberculosis comes from some previous case. Life comes from life, wheat from wheat, tares from tares, and tuberculosis from tuberculosis. If every present case were fully dealt with by diagnosis, observation, treatment, segregation and adequate control, there would be no future cases. There will be tares among our good grain to-morrow only as we allow tares to ripen and scatter in our fields of grain to-day. There will be tuberculous disease and tuberculosis deaths to-morrow only as we allow tuberculosis infection to slip through our fingers and scatter throughout families and through the whole land to-day.

Since each diseased organ is a potential scatterer, and usually a daily and hourly scatterer, of disease, the big job is to find diseased persons and make them safe, by treatment, by segregation, or education; safe for themselves, safe for their families, safe for their communities and safe for the country at large.

Community safety demands the treatment of tuberculous people as early, as late, and as long as treatment is necessary; the segregation or effective control of spreaders while they are spreaders, and as soon and as long as they are spreaders. Community safety thus demands many more beds than most countries or provinces have at the present time, beds waiting for the people, not people waiting for the beds. What is the use of finding sick and infective people if we can just wish them well and leave them as we find them?

When a man with far advanced disease, perhaps hopeless, is found and sent to a hospital, who is it that benefits? The man would often prefer to go on as he had done before. Treatment and segregation to him may mean almost unwilling imprisonment, though safety for the community. All diagnosis, treatment, segregation and observation of a tuberculous person is diagnosis, treatment, segregation and observation of a tuberculous community or state. Almost everything we do is partly for the man's good and partly for the state's safety. In so far as the man is treated to make the state safe, it is nothing but right that the state should help with the burden.

Doctor Stewart has pointed out the benefits resulting from treatment of the tuberculous in Sanatoriums, with the associated segregation and removal of a source of infection from the home. But all paients cannot be kept in sanatoriums throughout the whole of their infective periods, nor have we sufficient hospital and sanatorium beds for all our infective cases at the present time. Many must be cared for at home while awaiting sanatorium treatment or after a period of sanatorium treatment. Conditions at home may be such as to warrant carrying on treatment at home in some cases. Instruction and supervision are essential. This should demand combined effort of the physician and the health

department. In the case of the poor the health department may have to assume the whole responsibility. How can this be done without a full time health organization with public health nurses?

Notification and follow up is the basic principle of prevention of human infection in tuberculosis.

I think I am correct in stating that notification of tuberculosis is required in every province of Canada. But why, in a town or rural municipality, without a full time health officer or public health nurse, should Dr. Brown notify his neighbour Dr. Smith that Mrs. Jones has tuberculosis? What can Dr. Smith as health officer do about it more than Dr. Brown himself can do?

To carry out an effective scheme for discovery and prevention of tuberculosis we must have a full time health service fully equipped to deal with the situation. The city of Hamilton has demonstrated what can be done by intensive work in lowering the death rate from tuberculosis. The demonstration at Three Rivers is another example of what intensive efforts can accomplish. The organization of district health units as developed by Dr. Lessard in Quebec will make such intensive work possible in rural communities. If all our provinces can develop effective public health units and apply our present knowledge of preventive methods in tuberculosis, we should see a marked further decline in morbidity and mortality from this disease.

The statement from Doctor Stewart deals with the prevention of pulmonary tuberculosis—always a human infection—which causes approximately 80 to 85 per cent of the deaths in Canada from tuberculosis. Tuberculosis of other organs responsible for the remaining 15 to 20 per cent of tuberculosis deaths may arise from either human or animal sources.

Thus any scheme for the prevention of tuberculosis infection in man is incomplete without dealing with bovine infection in man. Until such time as tuberculosis is eradicated from our milch herds all milk and milk products are possible sources of human infection, unless treated in such a way as to be made safe. In the present state of our knowledge, pasteurization—as defined by law—is the effective method.

The CHAIRMAN: We are now to have a paper by Dr. James W. Ross of Toronto on

OCCUPATIONAL THERAPY

Dr. JAMES W. ROSS (Toronto): Mr. Chairman, ladies and gentlemen, Dr. Primrose asked me to speak to you in a brief manner on occupational therapy. I feel that he might possibly have chosen somebody better qualified. However, I have been interested for the past several years in Toronto in the medical workshop, and tried to make up my mind as to the results that we are obtaining and I purpose making a few comments that may be of interest, especially from the point of view of the compensation boards and provincial industrial health.

In a quiet way, which is not realized by the great mass of people in this Dominion and in the Republic to the south of us, occupational therapy is rendering a real service to the community. The value of this branch of medical science may be estimated both in dollars and cents, and in the return to normal of the individuals so treated. As a consequence the country at large must benefit to a considerable degree.

This benefit has been realized by institutions such as the University of Toronto and in furthering the project the university has now a three year course for the specific purpose of training young women to act as aides in the government institutions, asylums, hospitals and workshops throughout the province as well as in private homes where such service is required. I need not dwell

further upon this subject except to say that the course is well attended and there is still a crying need for more aides. The curriculum may be obtained from the University of Toronto.

At the last Annual Meeting of the Ontario Society of Occupational Therapy held in the workshop in Toronto, I was very much impressed by the reports given by several of the aides on their year's work. In the larger mental hospitals the patients were very eager to have work to do and to be shown how to do it. They were also proud of their accomplishments. This surely makes for contentment and greater ease in handling this very difficult group of patients. Again, the reports from the institutions where crippled and incurable children and adults as well, are being cared for, these reports of daily observation by the aides show what a vast amount of work is being done to alleviate the mental anguish of the prisoners large and small; to help them pass the weary hours in learning something which will be of practical use; to teach them to earn, if not a living wage, at any rate the means of obtaining some of the luxuries we all enjoy.

Again it often happens that the aide may help to lighten the load in the home when the husband, although crippled, can be taught to make saleable articles and the sale of such can be arranged through the workshop.

However, on account of my activities in the workshop, I have been most deeply concerned with those cases sent in by the Workmen's Compensation Board and I can speak with a fair degree of accuracy in this respect.

I believe that the work has actually benefited the country to the extent of a considerable financial saving. Possibly we do not realize how much it means in dollars and cents to the community; the saving that is being made by occupational therapy in reducing the extent of disability and getting men back to work more quickly.

In connection with permanent disability, I understand that one of the large lumber companies has now appointed a full-time doctor to make a survey of their total disability cases with a view to reducing the pensionable disability. Occupational therapy has now been started in one place about forty miles from a railroad, away back in the woods, where disabled lumbermen—people who are unable to do a full day's work—are sent until they can make some further use of their injured limbs. Four objects at least may be accomplished by occupational therapy:—

1. The extent of a man's permanent disability may be greatly reduced;
2. The malingerer may be apprehended;
3. The patient's mental attitude and local physical condition can be improved pending further surgical treatment;
4. The patient can be trained to use his injured limb which he could not do "on the job" for his employer will not pay him until he can do his work.

Let us analyse these facts and see what they mean.

It is a well-known fact that most injuries are benefited by use of the part or training of neighbouring structures to assume the function of those whose function is lost. When a man comes before the board for an estimation of his total permanent disability we may therefore assume that if he has been trained to make the best of things and use the injured limb to its utmost his disability will be less than it would otherwise have been. I have in mind several cases wherein this has been true—for example men with fractured femurs not able to walk, in possibly three months have been able to get around. Crushed hands: It is surprising how useful a hand can become sometimes where otherwise without using it one might think the case is hopeless.

Last year in my report in Toronto I referred to "Valuable therapeutic tests". When I give you the lists of cases to which this remark applied you will see that I was able from my own observation and that of the aides who were

instructing these men to make a fairly accurate report to the Compensation Board. One was a functional nerve lesion, another was a Pott's fracture, another a railroad spine, another a median nerve lesion (unrepaired) and so on. I don't believe we make many mistakes in sizing up the situation. I well remember one man who held out until he found that we knew all about him and then turned completely around and worked hard to reduce his disability and quite successfully at that.

There is often a long period of inactivity in surgical cases as it is absolutely essential to wait until the chance of infection is reduced to a minimum before operating upon an injured limb. This period is trying to the patient (also to his wife sometimes) and still more disastrous to the muscles and joints if they are not exercised. The time for physiotherapy is while the wound is healing in the hospital or immediately on discharge. Then comes the active use of the injured limb in the workshop, or "on the job" if his employer will accept him until something further can be attempted in surgery.

These are interesting cases and it is greatly to the credit of occupational therapy that after operation the cases very often return for further work because the doctor feels that something was accomplished originally in keeping the patient fit.

The question arises, in connection with the Compensation Board cases, why not let the man get back to work? The answer is not far to seek. His employer will not take him and pay him for work which he cannot do. Take for instance the simple job of filling motor cars with gasoline. If a man has lost several fingers and weakened his grip he cannot even use the hand pump. Others won't or can't do the pumping for him always so he loses his job.

In just this type of case will occupational therapy fill the gap.

In order that the treatment may be of greater benefit to the individual and to the State it is necessary that the work be supervised by a competent surgeon. In co-operation with the Workmen's Compensation Board the patients sent for treatment are examined twice a month at the workshop. A description of the case is sent by the board at the time of admission, covering such facts as the date of injury, nature of injury, present condition and any operative procedures which have been carried out. When the patient is first examined a note is made and a report is sent to the Board regarding his suitability for treatment, results to be expected and his present condition. In some cases, especially those of long standing, no benefit can be expected and no attempt is made to treat the case.

After a period of treatment I consider that the patient should be examined by his own doctor and a report should be sent by him to the Compensation Board. In this manner gross improvement can be noted and the board will be duly informed when the doctor considers further operative measures indicated. I refer particularly to nerve suture, tenotomy, tendon transplantation, and the breaking down of joint adhesions. A further benefit to be derived is that the doctor's interest in the case is kept up and he is made to feel that the patient is still his own patient in spite of the fact that he is not giving him any active treatment.

At times, the type of work which some individual patient may be doing is not that best suited to the reduction of his disability. A word to the aide in charge will therefore benefit the patient, and the time and place for this suggestion is when the consultant is examining at the workshop.

In conclusion I may say that I believe we may expect even better results in the future in civil life, than those obtained during the war by occupational therapy.

The Chairman: I will now call upon Dr. G. Harvey Agnew to give us an

INTERIM REPORT OF THE MEDICAL SURVEY OF CANADA

which is being carried out by the Canadian Medical Association.

Dr. G. Harvey Agnew (Toronto): Mr. Chairman, ladies and gentlemen, this report is not a final report, by any means, for answers are still coming in and we do not desire to make a final tabulation for several weeks yet. However, in view of the representative group present at this Conference on Medical Services, it was considered desirable that a preliminary report, at least, be presented here. A more detailed analysis and study will be undertaken during the next few months and, when completed and presented to council, will be published in the Journal and possibly in pamphlet form.

The details of the questionnaire sent out by our office are familiar to you all. You will have noted that not only do we make inquiry concerning the economic, hospital and other details relating to the practice of medicine, but that some effort has been made to ascertain to what extent the men practising medicine have found their undergraduate training to fit them for their later work.

Already a large number of replies have been received—over twelve hundred. These have been tabulated by provinces and by division into large city (over 50,000), small city (20,000 to 50,000), town (2,500 to 20,000), and village (under 2,500) practices. It is rather premature to draw definite conclusions, for subsequent replies may alter observations very materially, but sufficient returns have been received to enable us to judge the general direction of our ultimate conclusions.

We have not asked for signatures. We realize that the opinion of some astute observer, well qualified to comment, may be overlooked and averaged with others not so valuable, but the frankness that is possible with an anonymous reply has given us unvarnished statements which we might not have been able to obtain otherwise. And I may assure you, that some of these replies call a spade a spade.

The average age of our doctors seems to be in the middle forties. The youngest average age is being returned from the "village" groups in Alberta and Saskatchewan. In Ontario, the four groups, large city, small city, town, and village average almost parallel ages, thus casting some doubt upon the oft repeated statement that the young men now refuse to leave the cities.

There is an overwhelming verdict that there is no shortage of doctors *in the districts from which reports have been received.* The few replies commenting upon a local shortage refer in the main to small centres on the prairie. Of course great areas in the northern and sparsely settled portions of our provinces, wherein a real shortage exists, are not represented in these replies. The problem thus suggested seems to be one of providing medical services to the pioneer districts, not to the more settled areas.

Interesting data are being gathered concerning the average number of people per doctor in Canada. The actual figures are being reserved for the final report, but there are indications that this figure will prove to be very close to the ratio of twenty years ago.

It is surprising how many doctors reply that they are not making a fair living. Approximately two out of fifteen replying are in this unfortunate state. The highest percentage so reporting is in rural Alberta with the large cities of Ontario and Montreal coming next.

About one-third of the doctors state that their districts are lacking in hospital accommodation, this shortage being most marked in Montreal, Vancouver,

and in rural Alberta and Saskatchewan. One-third report inadequate pathological laboratory service; on the other hand, very few report a lack of X-ray service.

Medical Education

The second part of the questionnaire which requested opinions on medical education as considered in the light of the experience gained in actual practice has elicited a very interesting response. The detailed and sometimes voluminous replies—even up to eight pages—manifest the keen interest taken by graduates in medical education. The great majority replying were satisfied with their training and many spoke most appreciatively of the work of their teachers. Others, however, found considerable fault with educational methods.

One realizes that some of these criticisms may have been penned hastily or without a full realization of the problems facing our college educators. On the other hand, many signed opinions were received from men and women with national reputations who appreciate teaching and practical needs and difficulties from both sides of the academic wall. All in all, they present an interesting cross-section of graduate opinion.

The general consensus of opinion will be considered at greater length in the final report. It may be advisable at this stage to refer merely to some general observations noted in the tabulation of these replies. There is, as may be anticipated, considerable comment on the lack of practical instruction in the undergraduate course. The comment is also made that too much of the extra time added to the course at the present time is being absorbed by pre-clinical subjects. One practitioner (a well-known surgeon) who tersely comments "Cut out the dogfish cartlidge drawing" epitomizes the views of many. Others favour more pre-medical education "to improve the critical and logical faculties," although one graduate of the "combined" arts and medical course thinks it is admirable for the research worker but not designed for the practitioner in a small centre.

The ethical training, or lack of it, came in for some comment, many regretting that they, or rather their colleagues, had not had more grounding in this subject; one cynically, yet sadly, remarks that he "soon learned the vital lesson to regard his medical confreres, not as friends, but as business enemies." Others feel that the preservation of the fine old traditions of the profession will require the selection of students upon other than academic qualifications alone. "We need honest, kindly, sympathetic doctors of the 'old school'—not conceited snobs, exploiters or easy-going bridge or golf fiends!"

These are but a few of the many questions raised in this survey and we anticipate that the final tabulation which will be completed this winter will enable organized medicine to gain a better comprehension of the economic situation, the problems, the handicaps and the viewpoints of the men in practice.

Report of Resolutions Committee, presented by Dr. H. E. Young, Victoria.

RESOLUTIONS PASSED AT THE THIRD CONFERENCE ON THE MEDICAL SERVICES IN CANADA, OTTAWA, NOVEMBER 21 AND 22, 1929

1. *Re* Honourable Dr. King

The Third Conference on the Medical Services in Canada, composed of delegates from all the provinces of the country, and representative of its many medical activities, desires to place on record its sincere appreciation of the courtesy of the Hon. Dr. J. H. King, Minister of Pensions and National Health, and of the speaker of the House of Commons, in placing at the disposal of the

conference an assembly room in the House of Parliament, in furnishing stenographic reports from the Hansard staff, and for the generosity of the Government in undertaking the cost of publishing the proceedings of the conference.—*Approved.*

2. *Re* Narcotic Drugs

Whereas the Conference on Medical Services in Canada regrets the deplorable lack of accommodation in Canada for the treatment of drug addicts, we beg leave to suggest that the Canadian Medical Association suggest to the various provincial governments the desirability of amending their Hospital Acts in such a way as to make provision for the care and treatment of drug addicts in such institutions as the government may designate for this purpose, and that such institutions be empowered to retain these addicts as being legally committed for such periods of time as those in charge of their treatment may deem necessary to secure the best results. Furthermore, that such designated institutions be properly reimbursed for the added expense of properly caring for such drug addicts.—*Approved.*

3. *Re* Hospital Care of Mariners

The Conference on the Medical Services in Canada learns with gratification that the care of sick mariners comes within the purview of the federal government through its Department of Pensions and National Health, and also that the government imposes upon vessels arriving in Canadian ports, a tax to defray the hospital, nursing and medical cost of caring for such patients. The conference would, therefore, most respectfully submit for the consideration of the Minister of Pensions and National Health that the tax levies upon the vessels be made adequate to enable the fund to remunerate the members of the medical profession responsible for the care of such cases by the payment directly to the doctor, or fees which shall be at least equivalent to those of the Workmen's Compensation Boards in those particular provinces, and that, in the meantime, in those cases where a composite, all-embracing fee is paid to the hospital, the federal Government insist upon the proper division of this fee with the attending surgeons or physicians.—*Approved.*

4. *Re* Post Graduate Lectures

The Conference on the Medical Services in Canada desires to pay special attention to what the chairman, Dr. A. T. Bazin, had to say upon the important topic of the post graduate lectures that have been given for several years under the auspices of the Canadian Medical Association, through the generosity of the Sun Life Assurance Company of Canada, and would express the hope that these valuable lectures may be continued, and would so desire to record the feeling of this conference.—*Approved.*

5. *Re* Future Conferences

Whereas the discussion of the problems presented to this Conference on Medical Services has demonstrated the value of and the need for such periodic consultation of representatives of the various medical bodies and organizations, be it resolved that this Conference on Medical Services in Canada request the Canadian Medical Association to continue these conferences at such intervals as may be decided by its council.—*Approved*

6. Vote of Appreciation

That those worthy of it may receive merited meed of praise, it is resolved that a very hearty vote of thanks be recorded for the valuable services of Dr. Alfred T. Bazin and Dr. T. C. Routley, in bringing the Third Conference on the Medical Services in Canada to such a successful fruition.—*Approved.*

The Chairman: I wish to thank the members of the two committees, and particularly the Resolutions Committee, for what they have done to facilitate the business of the conference, and also to thank every one present for the sympathy with which the rulings of the chair have been accepted.

The conference thereupon adjourned.

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